OAKLAWN

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize Oaklawn Psychiatric Center, Inc. and the other party below to release information about me. I understand that:

- **Unless I cross out one or more of the following items, this may include information about the treatment/diagnosis of 1) MENTAL HEALTH; 2) SUBSTANCE USE DISORDER; 3) COMMUNICABLE DISEASE test results, including TB and AIDS/HIV (the virus that causes AIDS); and 4) my own or my family's GENETIC TESTING information. (If I limit this authorization, Oaklawn may not be able to disclose any information.)**
- Except for Substance Use Disorder treatment, the information may be re-disclosed by the person(s) receiving it and no longer protected by the federal privacy regulation. I may request a list of disclosures at any time.
- I may refuse to authorize disclosures (excluding disclosures for treatment or operational purposes) without affecting my ability to obtain treatment, payment, enrollment or my eligibility for benefits.
- I may revoke this release at any time by notifying Oaklawn Clinical Records, P.O. Box 809, Goshen, IN 46527, (574) 533-1234. Oaklawn is not liable for documents sent in the interim between authorization and revocation, documents that do not require an authorization, releases where the legal authority has changed, or releases made under an appropriate court order.

CLIENT:

Name: _____ Birth Date: _____

Address: _____

City, State, Zip: _____

Phone #: _____ Soc. Sec. #: _____

OTHER PERSON, ORGANIZATION OR ENTITY:

Is this a Treatment Provider? ☐ Yes ☐ No

Name: _____

_____

Address: _____

City, State, Zip: _____

Phone #: _____ Fax #: _____

1) **I am authorizing this release** *(check all that apply):* ☐ Verbal communication ☐ Copies of records ☐ Correspondence

2) **For this purpose** *(check all that apply):* ☐ Coordination of services ☐ Client's request ☐ Other *(specify)*:

3) *(Optional)* **Timeframe:** Limit the information to these treatment dates – from: _____ through: _____

4) **Oaklawn may release** *(select Core Care Documents or individual documents*):*

☐ Core Care Documents (may include Assessment, Diagnosis, Labs, Medication, Plan of Care, Physician/Prescriber Treatment Notes, Treatment Summary)

☐ Physician/Prescriber Treatment Notes
☐ Attendance Report
☐ Assessment and Diagnosis
☐ Verbal Exchange—Unlimited

☐ Lab Results
☐ Plan of Care
☐ Treatment Summary
☐ Medications

☐ Verbal Exchange—Limited to (provide explicit description):_____

☐ Other Specific Items (be very specific – no general terms): _____

* If authorized above, Substance Use treatment information may be included.

5) **Oaklawn may request:** →

☐ Core Care Documents (may include Assessment, Diagnosis, Labs, Medication, Plan of Care, Physician/Prescriber Treatment Notes, Treatment Summary)
☐ Reports (School, Court, DCS, Probation)
☐ Diagnostic Test Results
☐ Specific Items: _____

Send to the attention of: _____

At this Oaklawn address:

☐ P.O. Box 809, Goshen, IN 46527
☐ 2600 Oakland Ave., Elkhart, IN 46517
☐ 1411 Lincolnway West, Mishawaka, IN 46544
☐ 415 E. Madison St. Bldg 200, South Bend, IN 46617

6) *(Optional)* **Expiration:** My authorization is valid for two years from the date signed unless I write an earlier date here: _____

7) **I have read this information and been offered a copy. I am the client, or I am authorized to act on behalf of the client to authorize the use or disclosure of this information. If the client is a minor receiving treatment for a substance use disorder, they must sign the form. The parent/guardian would still authorize the release of any medical/mental health treatment information:**

_____ _____ _____

Signature of Client | Date *(required)* | Signature of Witness

_____ _____

Signature of Legal Representative | Relationship to Client *(required)*

STAFF USE ONLY *(Required)*

Indicate immediate action: ☐ File only ☐ Release documents listed above ☐ Release documents listed here_____

☐ Request documents listed above ☐ Request documents listed here_____

If revoked—Date: Staff initials: ☐ Verbally OR ☐ In writing.

Form No. 41 Rev. 7/19

Name:

Client ID: DOB:

Oaklawn Psychiatric Center

AUTHORIZATION OF ROI

* A U T H R O I *

* R O I *

Client ID	Document Date

INSTRUCTIONS (Form #41)
*** = Required Items**

CLIENT INFORMATION*

Complete the client's name, current address, date of birth, and Social Security number. We must have at least two patient identifiers to process the authorization (i.e., name, chart number, birth date, or Social Security number). Also complete the bottom of the form, indicating the client name, date of birth and chart number.

OTHER PERSON, ORGANIZATION OR ENTITY*

Complete the other person or entity's name and address. Only one name may appear on an authorization. There are no exceptions. Provide complete information in this section.

For Substance Use Disorders:

- If the entity does not have a treating relationship with the client you must list an individual and the entity, or a general designation (i.e. all Probation Officers, all teachers, for example) and the entity.
- If the entity has a treating relationship or if the entity is a 3rd party payer, you can just list the name of the entity.
- If the Treatment Provider question is incomplete and it is not clear when records are requested, the release will be returned for clarification.

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1. **AUTHORIZATION*** - Indicate the type of information to be exchanged. Check all that apply.

2. **PURPOSE*** - Indicate the purpose for the exchange of information. Check all that apply.

3. **TIMEFRAME** (Optional) - If we are requesting or releasing documents, it's helpful to provide a timeframe. Keep in mind the HIPAA minimum necessary concept.

4. **OAKLAWN MAY RELEASE** - If the authorization is for the purpose of sending copies of documents, indicate exactly which documents should be sent. Otherwise, indicate that this is just for a verbal exchange or permission to release any documents should they be requested in the future.

5. **OAKLAWN MAY REQUEST** - If the authorization is for the purpose of Oaklawn requesting documents, indicate exactly what you need.

6. **EXPIRATION** (Optional) - The authorization will expire in two years unless an earlier date is indicated. We no longer will accept an "event" (e.g., discharge from Oaklawn services) because it is not manageable with our electronic record functionality.

7. **SIGNATURES/WITNESS*** - The client signs and dates the form. If the client is a minor in a substance abuse program, they must also sign the form. If a parent/guardian signs the form for a child, identify the relationship. If a Power of Attorney signs, a copy of court papers must be obtained for the chart. A witness is not required by law but highly desirable. If the form is signed outside of Oaklawn, the witness may be anyone over the age of 18 and does not need to be notarized.

FOR STAFF USE ONLY*

- The staff person completing the form should indicate what is to be done at this time. Just file it for now? Release Oaklawn documents now? If so, which ones? Request documents now? If so, which ones?
- In the future, if the client decides to revoke the authorization, the date will be documented here with staff initials.

VALID AUTHORIZATIONS:

The authorization form needs to be complete before it can be processed. Keep in mind that the form will be returned if any of the following are true:

- There are not two patient identifiers on the form.
- A request has been made to immediately send or request documents but there isn't a complete address on the form.
- The signature of the client/guardian is missing or the signature date is missing.
- Someone other than the client or parent (for child) signed the form and we don't have documentation of that legal relationship in the client's record.
- More than one person/entity was specified on the authorization. Only one name/entity can be listed.
- One or more required items are blank.
- The "Staff Use Only" section is incomplete.
- "The Other Person, Organization, or Entity" section was not completed correctly for a client receiving treatment for a substance use disorder. See guidance above.