OAKLAWN

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

CLIENT Name _____ Birth Date _____

Phone # _____ Soc. Sec. # _____

Address _____ City, State, Zip _____

I authorize Oaklawn Psychiatric Center, Inc. and the party(ies) below to share information about me. **Unless I cross out one or more of these items, I understand this may include the assessment/diagnosis/treatment of 1) MENTAL HEALTH; 2) SUBSTANCE USE DISORDER protected by 42 CFR Part 2; 3) COMMUNICABLE DISEASE including TB and AIDS/HIV; and 4) my family's or my own GENETIC TESTING, and**

- The information may be re-disclosed by the recipient and no longer protected by the federal privacy regulations, except for Substance Use Disorder treatment information.
- I may decline certain disclosures without affecting my access to treatment, payment, enrollment or eligibility for benefits.
- I may revoke this release at any time through Oaklawn Clinical Records, PO Box 809, Goshen IN 46527 (574) 533-1234. Oaklawn is not liable for information released before the revocation, when authorization is not required, or when required by law.

1) I AUTHORIZE DISCLOSURES TO

Name _____ Phone _____ Fax _____

Address _____ City, State, Zip _____

2) OAKLAWN WILL RELEASE – check all that apply

☐ **Core clinical records** (may include Assessment, Diagnosis, Labs, Medication, Treatment Plan, Prescriber Notes, Summaries)

☐ **Communication & Correspondence** (verbal, written, electronic)

☐ **These items:**

☐ Assessment	☐ Attendance	☐ Billing Records
☐ Diagnosis	☐ Labs/Diagnostics	☐ Medications
☐ Treatment Plan	☐ Prescriber Notes	☐ Treatment Summary
☐ Other: _____		

3) OAKLAWN WILL REQUEST - send to PO Box 809, Goshen IN 46527, attention: _____ FAX _____

☐ Minimum necessary records & communication ☐ Reports (School, Court, DCS, Probation) ☐ Office notes

☐ Diagnostic Test Results ☐ Specific items: _____

4) OPTIONAL

- This authorization is for Coordination of Services unless I enter another purpose here: _____
- This is not limited to a treatment timeframe unless stated here: _____
- This is valid for two years unless I write an earlier date here: _____

5) I have read this document and been offered a copy. I am the client or may legally act for them. A parent/guardian must authorize the disclosure of health/mental health information for a minor. If substance use information is included, the minor must sign.

Client Signature _____ Date *(required)* _____ Signature of Witness *(preferred)* _____

Signature of Legal Representative _____ → Relationship to Client *(required)* _____

STAFF USE			
	CLINICAL RECORDS ACTION:	☐ Send documents listed in #2	☐ Send only: _____
		☐ Request documents listed in #3	☐ Request only: _____
	TO REVOKE: _____ Date	_____ Staff Signature	_____ Staff Name

Form No. 41 Rev. 7/23

Name:

Client ID: DOB:

Oaklawn Psychiatric Center

AUTHORIZATION OF ROI

* A U T H R O I *

Client ID	Document Date

* R O I *

INSTRUCTIONS (Form #41)

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.

I AUTHORIZE DISCLOSURES TO

Complete the other person or entity's name and address. More than one name may appear on an authorization, meaning both parents, foster parents, etc. can be on the same form. Provide complete information in this section.

OAKLAWN WILL RELEASE

There must be at least one of the options checked in order for Oaklawn to release any information. If therapy notes or other items not listed are to be released, they must be written in as Other.

OAKLAWN WILL REQUEST

There must be at least one of the options checked in order for Oaklawn to request any information.

OPTIONAL

This section provides the purpose of the authorization, any timeframe of treatment the authorization is limited to and the length of time the authorization is valid. Any changes to these items need to be indicated at the time the authorization is signed.

SIGNATURES

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. Other than biological/adoptive parents, a copy of the court order/other legal relationship paperwork 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. Oaklawn does not need to observe the witness signing.

FOR STAFF USE ONLY

- All authorizations are placed in the document library in the client's ECR. The staff person completing the form should indicate if Clinical Records should send 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 the staff signature and printed staff name. NOTE: Revoking the authorization for one individual/collective group revokes the entire authorization. A new form would need to be completed to continue communicating with all others.

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.
- If both the Release and Request section are blank.
- 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.