E.B. Evaluations, Inc.

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Address: 624 East Main Street
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Release of Information

Client Name:		Date:	
Current Address:		DOB:	
		Social Security #:	
Guardian Name:		Guardian Address:	

I hereby authorize **E.B. Evaluations, Inc.** and _____
to communicate about the following protected information from my clinical record (those checked):

To be released to E.B. Evaluations, Inc.:

- ☐ Psychiatric Hospitalization Discharge Summary
- ☐ Psychiatric Treatment Records
- ☐ Toxicology Results
- ☐ Emergency Department Encounter
- ☐ Medical History/Treatment
- ☐ Medication List
- ☐ Psychological Treatment History
- ☐ IEP/ETR
- ☐ Work/School Attendance
- ☐ Work/School Performance
- ☐ AOD Treatment History
- ☐ Other: _____

The purpose of this exchange of information is to:

- ☑ Conduct a court ordered formal evaluation

The information exchanged should reflect material collected:

- ☐ In the last six months
- ☐ In the last year
- ☐ In the last five years
- ☑ Since first contact with the client

I may revoke my consent to release this information at any time except to the extent that action will have been taken or information released prior to the revocation of my consent. I understand that treatment is generally not a condition of my signing an authorization to release information. If I refuse to sign this authorization for the release of information, the evaluation referring entity will be informed. **This authorization form is valid until six months from application date or (if less than six months).** I hereby authorize the agency and its employees to release the designated information contained in my patient record or designated record set. I understand and acknowledge that this authorization extends to all or part of the information designated above. Generally, this information may not be re-released, but I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule. This information has been disclosed from records whose confidentiality is protected by Ohio Revised Code 5122.31, and Ohio Department of Mental Health Rules for Clinical Records 5119:1-7-11. This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part II. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure).

	Signature:	Name (Print):	Date:
Client/Guardian:			