

## AUTHORIZATION FOR RELEASE OF INFORMATION

I, \_\_\_\_\_, date of birth \_\_\_\_\_

hereby authorize the Ohio Department of Mental Health

to release my medical information to:

Specific identification of Person or Entity Authorized to Receive information  
Ohio State Highway Patrol

I authorize the following information to be released:

- Narrative Summary
- After care Services Plan
- Psychiatric Examination
- History and Physical
- Psychology Evaluation
- Social Work Assessment

- Progress Notes
- Lab Results
- Treatment Plan
- Consultation
- Orders

Dates of Treatment

- Records from other providers (specify or "all")  
Dates of any hospitalizations \_\_\_\_\_

- Other (specify):
- Dates of any hospitalizations \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_

This authorization includes release of records relating to ("X" appropriate boxes):

- Diagnoses and/or treatment for alcohol and/or drug abuse
- AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment
- HIV test results
- Diagnoses and/or treatment relating to other communicable diseases

Indicate here any additional exceptions or exclusions. If any, to information released:

This authorization for use/disclosure is for the following purpose:  
Application for employment - background information

My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enrollment in a health plan. This authorization will remain effective for **90(180 days (circle one))** unless an earlier date or condition/event is specified here \_\_\_\_\_ . However, I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that ODMHAS has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to:

Name and Address:

Signature of Individual/Guardian/Personal Representative	Date Signed	Print Name
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If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here: \_\_\_\_\_

**NOTE:** This information has been disclosed to you from records whose confidentiality is protected from disclosure by State and Federal law. ORC 5122.31, 42 CFR Part 2, and/or ORC 3701.243 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose.

**FOR OFFICE USE ONLY**

Staff Person Releasing information
Date Information Released