SAMARITAN BEHAVIORAL HEALTH, INC. (SBHI)
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize disclosure of health information for the release, review, sharing and exchange of the following information relating to my care from Samaritan Behavioral Health, Inc. and "Person or Entity" as identified below. This release covers all programs of Samaritan Behavioral Health, Inc. (SBHI): *SBHI-Atrium; Integrated Care Solutions; SBHI-CAM; SBHI-Miami County; SBHI-Preble; Substance Abuse Services; School Services; and Young Children's Assessment and Treatment Services (YCATS).*

Release of Information Expiration – This authorization will remain in effect until revoked or (choose one option):

❑ Date of discharge with SBHI; or ❑ Date specified by the patient (1-year max) _____

Samaritan Behavioral Health, Inc. (SBHI) SBHI is a Covered Entity/Part 2 Program.

AND

Name of Individual, Agency or Entity: _____

Person or Entity Category: ❑Individual ❑Treatment Provider ❑Training/Research ❑3rd Party Payer ❑Non-Treatment Provider (i.e. parole, court, school)

Address: _____

Phone#: Fax #:

Patient's Name: _____ Date of Birth: _____

Name at time of treatment: _____ Social Security #: _____

Patient's Address: Phone #:

For Third Parties Requesting SBHI Records, indicate date range of treatment records required: **Begin date**_____ **End date**_____

Only records within date range will be sent. **Charges for records requests may apply.** A new release MUST be completed for each new request.

I authorize the release, sharing and exchanging of my information for the purpose of: (check all that may apply during the time of release)

☐ Coordinating Treatment ☐ Continuity of Care ☐ Gathering Assessment Information for Treatment Planning ☐ Legal

☐ Mental Health/Alcohol & Drug Treatment ☐ Reporting Progress ☐ Patient Request ☐ Other: _____

This information MAY include treatment or rehabilitation for drug and/or alcohol abuse, psychiatric treatment, HIV Antibody Test (test for AIDS Virus) or AIDS and related conditions, IF they did occur. **I specify that this release/exchange is to include:**

☐ Attendance	☐ Treatment Plan - ISP	☐ Lab Results/Reports
☐ Treatment Summary: Mental Health (MH)/Alcohol/Drug (AoD)	☐ Transfer/Discharge Summary	☐ Medical information
☐ MH/AoD Diagnostic Evaluation / Update	☐ Psychiatric Evaluation	☐ Pharmacy/Medication History
☐ MH/AoD Treatment Progress Notes	☐ Pharmacological/Psychiatric Notes	☐ Court records
☐ Occupational Therapy Evaluation &/or Treatment	☐ Medications Prescribed	☐ Consultation
☐ School records / IEP/outcome measures/progress	☐ Crisis Evaluation/Plan	☐ Other:

Information may be shared by mail, fax, phone, in-person, verbally, or via an Approved Health Information Exchange.

Federal confidentially regulations prohibit the recipient of this released information from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. 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. ✦ Substance use disorder records of Part 2 programs disclosed pursuant to this Consent are protected by federal regulations & cannot be re-disclosed without my written consent unless otherwise provided for in the regulations. Any information disclosed pursuant to this Consent other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient. ✦ I might be denied services if I refuse to authorize disclosure of information for purposes of assessment, treatment, or payment relating to substance use disorder if refusal is permitted by state law. My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services. ✦ If I have authorized disclosure to a generally described group or class of participants in an entity which is not my treatment provider, upon my written request, I must be provided a list of entities to which my information has been disclosed pursuant to that general designation. **This authorization will remain in effect until revoked or on above expiration date. I understand that I may revoke or cancel this authorization at any time by submitting written revocation, "Revocation of Release Medical Information" form, except to the extent that action has been taken in reliance on this authorization.** *If client is a minor, both client and parent/guardian are asked to sign.*

_____ _____

Signature/Client Date **Name and Signature of Authorized Representative to Individual* Date

Relationship: ❑Parent ❑Legal Guardian ❑POA ❑Other_____

_____ **If the signature is not that of the client/patient, explain, including authority to sign*

Witness Date *on behalf of the client and documentary evidence provided.* SBHI-098 (01-2024)

SBHI Programs and Locations:

Integrated Care Solutions, School Services, YCATS:	▪ Elizabeth Place, 601 Edwin C. Moses Blvd, Dayton, OH 45417	▪ 937 734-8333	▪ Fax: 937 734-8339
SBHI – Atrium:	▪ 401 Atrium Dr., BH Outpatient, Middletown, OH 45005	▪ 513 974-6049	▪ Fax: 937-641-2664
SBHI - CAM:	▪ Elizabeth Place, 601 Edwin C. Moses Blvd, Dayton, OH 45417	▪ 937 734-9810	▪ Fax: 937 734-9830
SBHI – Miami Co. Ofc:	▪ 3031 N. County Road 25-A, Troy, OH 45356	▪ 937 440-7121	▪ Fax: 937 440-7110
SBHI – Preble Co. Ofc:	▪ 225 North Barron Street, Eaton, OH 45320	▪ 937 456-1915	▪ Fax: 937 456-2208
SBHI – Substance Abuse OP:	▪ Elizabeth Place, 601 S Edwin C Moses Blvd, Dayton, OH 45417	▪ 937 734-8333	▪ Fax: 937 734-4999