AUTHORIZATION FOR RELEASE OF INFORMATION

DeBalzo, Elgudin, Levine, Risen LLC (DELR)
23425 Commerce Park Road, Suite 104
Beachwood, Ohio 44122
Phone: 216-831-2900 Fax: 216-831-4306

Patient Name: _____Date of Birth: _____

Address_____

Telephone: _____Social Security #: _____

I authorize *(PROVIDER NAME)* employed by DELR to
Release to _____ Receive from _____ Exchange with ___

Facility/Individual _____

Address _____

Telephone: _____Fax: _____

Medical Information stored electronically or in paper format to be disclosed:

Entire record _____ Initial Assessment _____ Psychological Testing ____ School Evaluation/Tests _____
Clinical Progress Notes ____ Psychotherapy Notes _____ Laboratory Tests _____ Medical History_____
Alcohol/Drug treatment _____ Treatment Summary _____ Other: _____

Purpose and need for information: Treatment planning and continuity of care _____ Insurance/other reimbursement _____
Necessary for clinical/forensic/professional required evaluation _____ Other: _____

I understand that this information will be disclosed from records protected by Federal confidentiality rules 42 C.F.R. Part 2. The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. 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. I understand and acknowledge that this authorization extends to all or any part of records designated above, which may include treatment for mental illness, alcohol/drug abuse, and/or Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) test result or diagnosis.

This authorization can be revoked at any time by providing written notice to DELR. I understand that any information released prior to revocation cannot be retrieved and that DELR or its employees will not be held responsible for such. I hereby release DELR and its employees from all legal responsibilities that may arise from this act.

_____
Signature of patient / legal guardian / other person authorized to permit disclosure

_____Date _____
Printed name / Relationship to patient

_____
Signature of Witness

_____Date _____
Printed name

This authorization will expire in 180 days unless revoked.

DATE REVOKED: _____NAME(Printed): _____
SIGNATURE:]_____