

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_ hereby grant permission to authorized representatives of the Mental Health & Recovery Services Board of Stark County to release information concerning:

Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
to \_\_\_\_\_ of \_\_\_\_\_  
Name Agency/Organization

I authorize the disclosure of the following information: Name, Verification of Monthly Income and Source or Verification of Application for Benefits , Social Security Number & Date of Birth.

**Please Initial**

\_\_\_\_\_ I authorize to the release of the above information. I am aware that this information is disclosed from records whose confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit either party from asking any further disclosures of information shared to any person/organization not specifically listed on this form without permission.

\_\_\_\_\_ I do not authorize to release/receipt/exchange of any information.

Any exceptions or exclusions for information released is listed here: \_\_\_\_\_

1. This authorization will remain effective for 365 days, expiring on \_\_\_\_\_ unless an earlier date or condition/event is specified here \_\_\_\_\_. However, I understand that I **HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING**, by sending/providing such written notification to Program Consumer/Services Coordinator at Mental Health & Recovery Services Board of Stark County, 800 Market Avenue North, Suite 1150, Canton, OH 44702. I understand that a revocation is not effective to the extent that this Authorization has been relied upon for the use or disclosure of the protected health information.
2. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. If the Mental Health & Recovery Services Board of Stark County is the recipient, the Mental Health & Recovery Services Board of Stark County will only redisclose information as authorized or permitted by law.
3. My treatment/services will not be conditioned on whether I provide authorization for the requested disclosure.
4. I understand that I have the right to refuse to sign this authorization.
5. I further understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted by law.

I hereby state that I have read, or have had read to me, and fully understand the above statements as they apply to me and do herein expressly authorize to the disclosure of the above stated information for the purpose or need stated. I understand and acknowledge that this Authorization extends to all or any part of the records designated above.

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

*A copy of this signed Authorization shall have the same force and effect as the original.*

<b>For Office Use Only:</b>	
Recorded _____	By _____
Filed _____	By _____