Danielle Dronet LISW-S, LICDC
Cleveland Heights, OH
216.501.1730
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Authorization to Release/Obtain Information

The Following Are Authorized To: ☐ **Release/Disclose** **and(or)** ☐ **Obtain**

Organization and/or individual providing the information:

Address

City State Zip

Phone Fax

Organization and/or individual receiving the information:

Address

City State Zip

Phone Fax

Reason:

☐ Coordinate Treatment Other:

Type Of Information To Be Released/Obtained:

☐ Mental Health Assessments/Evaluations
☐ Treatment Plan/ISP/Treatment Updates
☐ Court Reports
☐ General Medical Records
(except HIV/AIDS related diagnosis and treatment)
☐ Other (specify):

☐ Partial Hospitalization Records
☐ HIV/AIDS related diagnosis
☐ Employment Records
☐ Progress Notes
☐ School Reports/Records/IEPIMFE

☐ Alcohol/Drug
☐ Assessment Results
☐ Treatment Results
☐ Urinalysis Results

Amount Of Information To Be Released/Disclosed:

☐ Information covering previous 6 months ☐ Information related to most recent admission
☐ Other amount of information (specify):

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Organization and/or individual providing the information

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 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.

Understand that I may see and copy the information described on this form if I ask for it. I also understand that the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. The health care providers listed above will not receive financial or in-kind compensation in exchange for using or disclosing my health care information.

This consent is subject to revocation at any time except in cases where information has already been released. Revocation applies to that date forward and not to information already shared. If not revoked, this consent will expire 180 days from the date of the authorization written below.

If not previously shortened, lengthened or revoked, this authorization will expire on: Date:

Signature of Client:	Printed Name:	Date:
Signature of Legal Guardian:	Printed Name:	Date:
Signature of Witness:	Printed Name:	Date:

A copy of this authorization shall have the same force and legal effect as the original.

Revocation of Authorization for Release of Information

As of the date and time noted below, I hereby revoke permission for Danielle Dronet/Center for Advanced Mental Health Practice to further release information to the above-noted person, except to the extent the program has already acted in reliance upon it.

Client/Legal Guardian	Date/Time	Witness Signature	Date/Time