DANIEL L. DAVIS, PH.D, ABPP (Forensic)
1335 Dublin Road Suite 201-B
Columbus Ohio 43215
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name **Date of Birth** **Social Security No. (optional)**

I hereby authorize: _____
(Person or Facility Releasing the Information)

To release to and/or receive from: **Daniel L. Davis, Ph.D. 1335 Dublin Road Suite 201-B**
Telephone 614.488.3680 Fax 614.369.1301 Email: drdandavis@drdandavis.com

The specific type of information to be disclosed is (check as many as apply):

- ☐ **MH/AOD Assessment**
- ☐ **Psychiatric Evaluation/Notes**
- ☐ **Psychological Report**
- ☐ **All clinical documentation**
- ☐ **BH Treatment Plan**
- ☐ **History and Physical**
- ☐ **Psych testing Report**
- ☐ **Billing/Financial**
- ☐ **HIV**
- ☐ **Physician Orders**
- ☐ **Discharge Summary**
- ☐ **Medical Reports**
- ☐ **Nursing Assessment**
- ☐ **Treatment Progress**
- ☐ **Rediscloure of Records from (Source)**_____
- ☐ **All Educational Records (e.g. IEP/504/ETR/Grades/Discipline/Attendence)**
- ☐ **Other (specify):** _____

The amount of information to be disclosed is information covering (check as many as apply):

- ☐ **Current episode**
- ☐ **Episodes occurring in the previous _____ months**
- ☐ **Other dates/episodes (specify):** _____

The purpose or need for this disclosure is (check as many as apply):

- ☐ **To Transfer Client Care**
- ☐ **To Inform Referral Source**
- ☐ **To Inform Employer/EAP**
- ☐ **To Inform Court System**
- ☐ **To inform referral source for treatment, payment, or operations purposes**
- ☐ **To Inform Family**
- ☐ **Application for Provider Coverage**
- ☐ **At the request of the individual**
- ☐ **For payment purposes**
- ☐ **For Follow Up Care**
- ☐ **To Aid in Treatment**
- ☐ **For Discharge Planning**
- ☐ **Other** _____

I understand that this form is not required as a condition for treatment (except for certain court-ordered services) and that this authorization may be revoked any time except to the extent that action has been taken in reliance on it. This authorization will expire one hundred and eighty (180) days after the date of my signature unless otherwise stated below. I understand that I may shorten or lengthen the authorization period at any time by notifying Daniel L. Davis, Ph.D., ABPP in writing. The release of information is limited to the person or organization named above and may include HIV, AIDS, mental health, drug & alcohol information. This information may be released verbally and/or in writing via phone, fax, mail, or in person.

Specify date, event, or condition upon which the authorization will expire (expires 180 days from date signed if blank):

☐ 1 year from date signed ☐ Other date, event, or condition _____

I understand that information disclosed may be protected by law and may not be redisclosed without my written authorization or as otherwise authorized by law; however, I understand that Daniel L. Davis, Ph.D., ABPP cannot control the recipient's or any other person's use of the information after it is disclosed.

Prohibition on Redisclosure of Alcohol and Drug Abuse Patient Records (if applicable)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making 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 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Signature of Client **Date** **Signature of Parent/Legal Guardian / Other authorized representative** **Date**

_____
Witness **Date**

IF APPLICABLE: Signature not obtained because (signature of two witnesses required):

☐ Person is incapacitated ☐ Medical Emergency/Continuity of Care ☐ Verbal Consent Obtained

_____ _____
Signature of Witness Date Signature of Witness Date

IF APPLICABLE: I hereby revoke this authorization for release of information on the date signed below:

_____ _____
Signature of Client/Examinee Signature of Witness