**Central Ohio Counseling, Inc.**
**1035 Proprietors Rd., Worthington, OH 43085**
**(p)614-785-1115 (f) 614-785-0095**

# Authorization to Disclose Health Information

| Patient Information | |
|---|---|
| Name (first, mi, last) | COC Provider Name |
| Address | City, State, Zip |
| Date of Birth | Phone Number |

| Release Information TO the following person(s) or organizations: | | | |
|---|---|---|---|
| Name/Organization | | Attention: | |
| Address | | City, State | Zip |
| Phone | Fax | Email | |

Purpose of Release:_____
Coordination of care, Disability, Insurance, School, Legal, Personal Use

Method of Release:

___Paper copy to be picked up (fee may apply) ___Fax ___Encrypted Email

Date of service to release: From_____ To:_____
If not specified the LAST 6 MONTHS will be released

Information to be released:

___Office Visit Notes ___History/Physical ___Emergency Record

___Labs ___Medications ___Billing Records

___Appointment Information ___Demographics

I, the undersigned, authorize Central Ohio Counseling, Inc. to release health information as indicated/described above. I understand and acknowledge that the requested information may contain information regarding physical and mental illness, HIV or AIDS diagnosis, and/or drug/alcohol abuse. **This authorization does not include permission to release outpatient psychotherapy notes as defined below*. Release of psychotherapy notes requires separate authorization.**

**Authorization and consent will expire one year from the signature date**, unless revoked by me (or my legal representative) through written notice presented to Central Ohio Counseling, Inc.'s practice manager. Any revocation will not apply to information that has already been released in response to this authorization. All health information released electronically from Central Ohio Counseling, Inc. will be sent with encryption; however I understand that the recipient of the information may not have encryption software when opening the information and my health information may no longer be protected.

_____/_____ _____/___/_____
Signature of Patient/Patient's Personal Representative Printed Name Date

_____/_____ ___/___/_____
Signature of Witness Printed Name Date

*Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.