Thrive Behavioral Health Center

Name

Date of Birth

Social Security Number

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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see 42 CFR 2.31).

The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 42 CFR 2.65.

If the client refuses to sign this authorization for the release of information, no information will be exchanged regarding this client's PHI. I further understand that I will not be denied services if I refuse to consent to a disclosure for other purposes.

I, the client, authorize Thrive Behavioral Health Center to (check one or both):

- [ ] release information
- [ ] obtain information

Name of person or agency that information is being exchanged with:

I authorize the release of the following information:

- [ ] Housing status
- [ ] Appointment Dates
- [ ] Emergency Situations
- [ ] Client Status
- [ ] Diagnosis
- [ ] Medications
- [ ] Physical Exam Results
- [ ] Psychiatric Evaluation
- [ ] Assessment Results
- [ ] Urine Drug Screens
- [ ] Treatment Summary
- [ ] Evaluation Results
- [ ] Discharge Summary
- [ ] Legal History
- [ ] Attendance
- [ ] Medications Prescribed
- [ ] Treatment Needs Identified
- [ ] Background Information
- [ ] Insurance

State the purpose of need for disclosure:

Seeking help for alcohol abuse

NOTE: I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC 5122.31), alcohol/drug use and/or abuse (42 CFR Part 2) and/or Human Immunodeficiency Virus (HIV/Acquired Immune Deficiency Syndrome (AIDS) test results or diagnoses (ORC 3701.24.3)

I hereby state that I have read and fully understand the above statements as they apply to me and do herein expressly consent to disclosure for the purpose or need and the extent or nature as stated above. I further understand that I may revoke this consent at any time, except where disclosure has already been made, or upon the occurrence of the event: the purpose for which disclosure is hereby authorized.

NOT VALID AFTER 12 MONTHS UNLESS OTHERWISE NOTED

Client Signature

Today's Date

The below portion is to be completed by a Thrive employee if consent is obtained verbally.

The client is unable to sign the document electronically,
but provided verbal consent on this date:

Date

Client Name-

First Name Last Name

Client Date of Birth-

Date

Witness Name

Witness Signature