Cleveland Clinic

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION THROUGH DRCONNECT
HOME HEALTH RELEASE OF INFORMATION FORM

Cleveland Clinic DrConnect Operations
3175 Science Park
Beachwood, OH 44112

Phone: 877.224.7367 (877.CCHS.EMR)
Fax: 216.445.9668
Email: drconnect@ccf.org

Patient:_____ SSN:_____

Clinic #: _____ Date of Birth:_____/_____/ _____

Address:_____ City:_____State:_____Zip: _____

Telephone: _____

I hereby authorize the Cleveland Clinic and its affiliates (collectively, "Cleveland Clinic") to release my health information as indicated below. **I understand and acknowledge that this release will include records of any treatment I have received for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results, diagnoses and treatment. This authorization does not include permission to release Psychotherapy Notes as defined below.* The release of Psychotherapy notes requires a separate authorization.**

Release To:_____ Telephone: _____

Address:_____City:_____State:_____Zip: _____

Reason for disclosure:_____.

Information to be disclosed: I understand and agree that my **complete and full medical record** will be released regardless of dates of treatment. The information released will include, but not be limited to, the following records:

• Alcohol and/or drug abuse treatment records • Mental health treatment records including treatment for mental illness • HIV tests, results, diagnosis and treatment
• Discharge summaries • History & physical • Laboratory reports • Operative reports • Pathology reports • Medications • Clinic/Progress notes • Diagnoses

This authorization is subject to revocation at any time except to the extent the action has been taken thereon. I may revoke this authorization at any time by contacting Cleveland Clinic at the contact information listed above. I understand that the recipient of my health information may be charged for the service of releasing medical information.

This authorization will expire sixty (60) days from the date written below, unless I specify an earlier date: _____ _____. I understand that information released pursuant to this authorization may remain part of my permanent medical record at Recipient. My health care (or payment for care) will not be affected by whether or not I sign this authorization. Once my health information is released, redisclosure of my health information by the Recipient may no longer be protected by law.

NOTICE TO RECIPIENT OF INFORMATION & ADDITIONAL PATIENT ACKNOWLEDGEMENT

The information disclosed pursuant to this authorization will contain any and all information contained in my medical record that is protected by Federal confidentiality rules relating to treatment provided by Alcohol and Drug Abuse Program (42 C.F.R. Part 2) and state law pertaining to the disclosure of HIV/AIDS information. **These rules prohibit Recipient 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 C.F.R. Part 2 relating to the disclosure of alcohol and drug abuse program information or state law pertaining to disclosure of HIV/AIDS information. A general authorization for the release of medical or other information is NOT sufficient for these purposes. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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

_____
Relationship if not Patient

**Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.*

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.*