



Name of Provider Assisting with Completion: _____

Date _____ Phone # _____

Email _____

Authorization for Release of Information for Recovery Requires a Community

Please return to Recovery@mha.ohio.gov; or fax to 614.728.8031

I, _____, date of birth _____ hereby authorize the release of my personal information to providers or agencies specifically involved in my transition and stabilization in the community, which includes:

- Ohio Department of Mental Health and Addiction Services (OhioMHAS)
- Ohio Department of Medicaid (ODM)
- Ohio County Alcohol, Drug, and Mental Health Boards (ADAMH)
- Providers contracting with OhioMHAS, ODM, and/or ADAMH

I authorize the following information to be released to providers or agencies specifically involved in my transition and stabilization in the community, as well as the evaluation of the program:

- Medicaid information, including claims data
- Community transition/HOME Choice documentation
- Documentation required for Recovery Requires a Community funding application
- Diagnoses and/or treatment for alcohol and/or drug abuse
- AIDS/AIDS Related Complex diagnoses and/or treatment
- HIV test results
- Diagnoses and/or treatment relating to other communicable diseases
- PASRR Information related to my time in an institution

Indicate here any additional exceptions or exclusions, if any, to information released:

This authorization for use/disclosure is for the following purpose:
To assist with my transition from an institutional setting into community.

My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enrollment in a health plan. This authorization will remain effective for 365 days, or (fill in date) _____. I understand I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that OhioMHAS has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to:

Name and Address:
Adam Anderson, 30 E. Broad Street, 36th Floor, Columbus, OH 43215

Signature of Individual/Guardian/Personal Representative:	Date Signed:	Print Name:
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If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. ORC 5119.27, 5119.28, 5122.31, and/or 42 CFR Part 2 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose.