Signature Health Release of Information

Client Name:		
Client Date of Birth:	Client Phone:	Client ID #:

I authorize Signature Health, Inc. to ☐ release to ☐ obtain from ☐ make verbal disclosures to

Name:	
Address:	
Phone:	Fax/Email:

For the purposes of: ☐ Continuity of care ☐ Coordinate Treatment/Services ☐ Legal
☐ Other (specify) _____
_____

Amount of Information to be Disclosed/Obtained:
Information from Dates _____ to _____

I authorize the release of the following checked items:

☐	HIV/AIDS Related Diagnosis/Treatment	☐	Substance Use Progress Notes	☐	Mental Health Progress Notes
☐	Mental Health Assessment/Summaries	☐	Psychiatric Evaluations	☐	Case Management Information
☐	Chemical Dependency Assessment/Summaries	☐	School Records/Observations	☐	Discharge Summary
☐	Diagnoses	☐	Medication Records	☐	Test Results (lab, radiology, pathology, Urine Drug Screens)
☐	Sexual Behavior Services Information	☐	Attendance/Appointment Lists	☐	Medical Information
☐	Treatment Plans	☐	Other (specify):		

I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol and drug abuse, all of which are protected under federal or state confidentiality regulations (42 CFR Part 2; 45 CFR Part 160 et. seq.; O.R.C. § 5122.31; O.R.C. § 3701.243) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that the health information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected under law. My failure to sign this authorization may result in my information not being released. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization. I understand that I may revoke this consent in writing at any time by providing written notice to the address and person listed below. Any revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked in writing, this authorization will expire one year from the date this authorization is signed or the date indicated: _____.

_____ Signature of Client	_____ Signature of Client's Legal Representative
_____ Date	_____ Legal Representative's Relationship to Client

Release of Information can be sent to the Medical Records Department
SH-medicalrecords@shinc.org or by fax to (440-269-2551)
Revocation of consent to release information may be made in writing to:
7232 Justin Way, Mentor, OH 44060, Attn: HIPAA Privacy Officer.

Staff Member Submitting Form: _____ Staff Witness: _____

Effective Date: 02/06/2024
Last Revised: 02/06/2024
Owner: Compliance