Authorization for Release of Mental Health Information

Inmate Name:	Inmate Number:	Date of Birth:

I hereby authorize: _____
to release my mental health information to:

Full Name and Address of Person/Facility:

Dates of Treatment:

Information I authorize to be released:

- ☐ Narrative Summary
- ☐ Social Work Release Summary
- ☐ Psychiatric Examination
- ☐ History and Physical
- ☐ Psychology Evaluation
- ☐ Social Work Assessment
- ☐ Progress Notes
- ☐ Lab Results
- ☐ Treatment Plan
- ☐ Consultation
- ☐ Orders
- Other (specify): _____
- ☐ _____
- ☐ _____
- ☐ _____

I understand that this information extends to all or any part of the records indicated above which may include treatment for psychiatric illness, alcohol and/or drug abuse, HIV test results, AIDS/AIDS Related Complex (ARC) diagnoses, and/or other communicable diseases, unless indicated below.

Indicate exceptions or exclusions, if any, to information released:
Reason for Disclosure:
This consent will remain valid for 180 days from the date of the patient's signature unless an earlier date is specified here:

This authorization may be revoked in writing by the patient at any time but shall not be retroactive for information released in good faith prior to receipt of the revocation.

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by State law. Section 5122.31 and/or Section 3701.243 of the Ohio Revised Code prohibit you from making any further disclosure of it without the specific written and informed release of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Inmate's Signature:			Date:
Witness Signature:	Date:	Witness Signature:	Date:

For Office Use Only
Staff Person Releasing Information:
Date Information Released:

DRC 5159 (Rev. 11/14)
Distribution: Releasing Person or Facility Mental Health File