

**GLENBEIGH  
AUTHORIZATION FOR RELEASE OF INFORMATION**

**P. O. Box 298  
Rock Creek, Ohio 44084**

**Phone: (440) 563-3400  
Fax: (440) 563-9661**

1. Patient Name \_\_\_\_\_ Patient Number: \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Phone # \_\_\_\_\_

2. I authorize Glenbeigh to release information to:  
Name of Recipient: \_\_\_\_\_ Phone# \_\_\_\_\_  
Relationship to patient (if any): \_\_\_\_\_  
Company Name :( if applicable) \_\_\_\_\_ Cell# \_\_\_\_\_  
Address \_\_\_\_\_ Fax# \_\_\_\_\_  
\_\_\_\_\_

**AND**  
I authorize \_\_\_\_\_ to release information to Glenbeigh.

**PCP** \_\_\_\_\_ **NONE** \_\_\_\_\_ **REFUSED** \_\_\_\_\_

**3. SPECIFIC INFORMATION THAT MAY BE RELEASED VERBALLY:**

<input type="checkbox"/> yes	<input type="checkbox"/> no	HISTORY & PHYSICAL EXAM	<input type="checkbox"/> yes	<input type="checkbox"/> no	DISCHARGE PLAN
<input type="checkbox"/> yes	<input type="checkbox"/> no	LAB REPORTS	<input type="checkbox"/> yes	<input type="checkbox"/> no	PROGRESS IN AFTERCARE
<input type="checkbox"/> yes	<input type="checkbox"/> no	PSYCHOSOCIAL ASSESSMENT	<input type="checkbox"/> yes	<input type="checkbox"/> no	DISCHARGE SUMMARY
<input type="checkbox"/> yes	<input type="checkbox"/> no	TREATMENT PROGRESS / PLANS	<input type="checkbox"/> yes	<input type="checkbox"/> no	PSYCHIATRIC / PSYCHOLOGICAL EVAL
<input type="checkbox"/> yes	<input type="checkbox"/> no	PROGRESS REPORTS	<input type="checkbox"/> yes	<input type="checkbox"/> no	ADMISSION NOTIFICATION
<input type="checkbox"/> yes	<input type="checkbox"/> no	DRUG SCREENS/BREATHALYZER	<input type="checkbox"/> yes	<input type="checkbox"/> no	OTHER (SPECIFY) _____

**4. DOCUMENTS TO BE RELEASED**

<input type="checkbox"/> yes	<input type="checkbox"/> no	HISTORY & PHYSICAL EXAM	<input type="checkbox"/> yes	<input type="checkbox"/> no	LAB REPORTS
<input type="checkbox"/> yes	<input type="checkbox"/> no	PSYCHOSOCIAL ASSESSMENT	<input type="checkbox"/> yes	<input type="checkbox"/> no	DISCHARGE SUMMARY
<input type="checkbox"/> yes	<input type="checkbox"/> no	PROGRESS REPORTS	<input type="checkbox"/> yes	<input type="checkbox"/> no	PSYCHIATRIC / PSYCHOLOGICAL EVAL
<input type="checkbox"/> yes	<input type="checkbox"/> no	TREATMENT PLANS	<input type="checkbox"/> yes	<input type="checkbox"/> no	DISCHARGE PLAN
<input type="checkbox"/> yes	<input type="checkbox"/> no	DRUG SCREENS/BREATHALYZER	<input type="checkbox"/> yes	<input type="checkbox"/> no	BACK TO WORK LETTER
			<input type="checkbox"/> yes	<input type="checkbox"/> no	OTHER (specify) _____

**AMOUNT OF INFORMATION TO BE RELEASED:**

5. This treatment episode only

6. Reason for disclosure: \_\_\_\_\_

7. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. **This authorization (unless revoked) expires one year from the date provided below.**

8. DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(Patient/Legal Guardian)\*\*  
Witness: \_\_\_\_\_ Date: \_\_\_\_\_

This information has been disclosed to you from records protected by Federal Confidentiality rule. The Federal rules prohibit you 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 (42CFR Part 2). A general authorization for the release of medical or other information is **not** sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

A photocopy or facsimile of this authorization will have the same authority as the original.

**REVOCAION OF RELEASE OF INFORMATION**

I hereby withdraw my consent for this release of information. \_\_\_\_\_  
(Signature) (Date) (Time)

I authorize **GLENBEIGH HOSPITAL** to inform the party listed above that I have **revoked** my consent to release any further information.

\*\*If other than patient's signature, a copy of legal papers verifying authority (e.g. Power of Attorney or Death Certificate) MUST accompany the authorization when presented.