



THE COUNSELING CENTER

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Dates of Treatment:** From \_\_\_\_\_ To \_\_\_\_\_

**Individual or Entity Requesting Records:**

**Telephone Number:** \_\_\_\_\_

**Purpose of Request (Optional):**

**Please indicate the specific records requested (check all that apply):**

- Diagnostic Assessments
- Treatment Plans
- Individual Counseling Progress Notes
- Group Counseling Progress Notes
- Case Management and CPST Individual Notes
- Laboratory and Urinalysis Results
- Primary Care Records
- Medication Information
- Medication-Assisted Treatment (MAT) Records
- Discharge and Transition Summaries
- Other (please specify):

Records from a Specific Provider (please specify):

**Authorization Expiration:**

This authorization will remain in effect for **three (3) months** from the date of signature unless an earlier expiration date or condition/event is specified below:

**Requesting Entity Name (Printed):** \_\_\_\_\_

**Signature of Requesting Entity:** \_\_\_\_\_

**Date:** \_\_\_\_\_

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by State and Federal law. ORC 5122.31, 42 CFR Part 2, and/or ORC 3701.243 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.