AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION TO MENTAL HEALTH & RECOVERY BOARD OF ASHLAND COUNTY'S BOARD'S BILLING MANAGEMENT INFORMATION SYSTEM

I, _____, authorize
Name of Client

_____ to disclose to
Provider Agency Name

Mental Health & Recovery Board of Ashland County (Board) and the Ohio Department of Mental Health and Addiction Services (OhioMHAS) the following information:

My name and other personal identifying information and information about the services provided to me (e.g. diagnosis, services provided, and dates of services) that is necessary to accomplish the following purposes:

- Enroll me in the billing management information system used by the Board and other county behavioral health boards
- Determine my eligibility for publicly-funded services
- Pay my provider for the publicly-funded services I receive
- Permit the Board to carry out its authorized legal responsibilities

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, my enrollment or eligibility for benefits, or payment for my services, except that I must authorize disclosure of this information to receive publicly-funded alcohol and drug addiction services. I understand that my service provider may disclose information necessary to obtain payment for, and carry out authorized legal responsibilities related to, my publicly-funded mental health services, including my enrollment in the publicly-funded system and determining my eligibility for those services, even if I do not authorize disclosure.

I understand that the information contained in the Board's billing management information system will only be used or disclosed by the Board as authorized by me or as permitted by applicable law. I understand that other county behavioral health boards that pay for services provided to me will only access information about me that is maintained in the Board's system as authorized by me or as permitted by applicable law.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 "HIPAA" (45 CFR 160 & 164) and cannot be re-disclosed to a third party without my written authorization unless permitted by the regulations. I also understand that my mental health records are protected by HIPAA but if the recipient of my information is not subject to HIPAA, they may no longer be protected by state or federal law and therefore subject to re-disclosure to a third party.

I also understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it. If not previously revoked, this authorization will expire at the time the services provided to me by the above-named Provider Agency ends.

_____ _____ _____
Signature of Client/Legal Representative ***Date*** ***Date of Birth***

_____
Printed Name and Authority of Person Signing on Behalf of Client (if applicable)

Client refused to sign (check if applicable): _____ Reason for Refusal:_____

*NOTICE TO RECIPIENTS OF ALCOHOL AND/OR DRUG TREATMENT INFORMATIO*N: *This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.*