Phone: 216-252-1399
Fax: 216-252-1409

14538 Grapeland Avenue
Cleveland, Ohio 44111

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____

SS #: _____ Phone: _____

Provider Name:_____

I hereby authorize Daily Behavioral Health, Inc to exchange medical information and pertinent records with:

Name: _____ Phone: _____

Organization: _____

Address: _____

Fax: _____

Type of Information to be disclosed:

□ treatment summary	□ progress notes	□ psychiatric records
□ educational testing	□ discharge summary	□ written reports
□ complete chart	□ psychological testing	□ verbal communication

Purpose of Disclosure:

□ coordination of care □ patient request □ parent/guardian request

□ _____

_____ _____

Patient Signature (Parent/Guardian if under 18) Date

_____ _____

Witness Date

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Daily Behavioral Health has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Daily Behavioral Health, Inc at 14538 Grapeland Avenue, Cleveland, Ohio, 44111 to be effective. Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form. Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. This release will automatically expire twelve months from the date signed. Copies of medical records not intended for medical reasons will be subject to a charge.

Faxed/Mailed Date: