



# Authorization for the Release of Substance Use/Mental Health Records

I, \_\_\_\_\_ authorize  
Patient Name Date of Birth Phone Number

## WHO IS RELEASING AND RECEIVING INFORMATION?

Required

### Discloser (who is sharing the information?)

### Receiver (who is getting the information?)

Name/Organization: \_\_\_\_\_

Name/Organization: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

## WHAT INFORMATION DO YOU WANT SHARED?

Required

All records, **OR** only the specific types of records:

Appointments

Attendance

Clinical Treatment Plan

Demographics

Diagnosis

Discharge Summary

Health Assessments

Insurance Information

Lab Results

Medical Progress Notes

Medication Information

Psychotherapy Notes \*

Referral Information

Toxicology Results

Treatment Status

Other: \_\_\_\_\_

## RELEASE INFORMATION ONLY FROM THESE DATES

Required

All dates of service

Specific dates: **Start:** \_\_\_\_\_ **End:** \_\_\_\_\_

**NOTE:** If you do not choose a date range, the records will only include those from the past year, starting from the date of this authorization.

## REASON OR PURPOSE OF CONSENT

Required

Coordinating Treatment

Legal Services

Payment / Benefits

Provide Information

Other (specify): \_\_\_\_\_

## WHEN SHOULD THIS CONSENT EXPIRE?

This consent will expire 90 days after discharge from CompDrug unless otherwise listed below.

Upon specific date/event: \_\_\_\_\_

## HOW SHOULD THE RECORDS BE SENT?

Required

Secure Fax: \_\_\_\_\_  
(xxx) xxx-xxxx

Encrypted Email: \_\_\_\_\_  
name@email.com

## REVIEW & SIGN

Required

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date Signed (MM/DD/YYYY)

\_\_\_\_\_  
Printed Name (If not signed by patient)

\_\_\_\_\_  
Relationship to Patient

\*Psychotherapy notes and substance use disorder (SUD) counseling notes are afforded special protection under federal law. Disclosure of these records requires a separate authorization. Patients do not have a right to access psychotherapy notes under federal law, even when an authorization is signed

## RIGHT TO REVOKE

Except to the extent that the ROI has already been acted upon, this authorization will remain in effect until it is revoked or until it expires on the date or event specified. I understand that I may revoke this authorization at any time by signing below. Signed revocations may be sent by mail, fax, or email to the recipient below.

### CompDrug – Medical Records

547 E 11<sup>th</sup> Avenue, Columbus, OH 43211

614-291-0118

MedicalRecords@compdrug.org

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date (MM/DD/YYYY)