CompDrug

Instructions to Complete Authorization for the Release of Health Information Records

Step 1: Patient Information Patient's full name Patient's date of birth (MM/DD/YYYY) Your phone number	Please provide: • Full legal name • Date of birth (MM/DD/YYYY) • Current phone number Your name and date of birth help us correctly identify you. Your phone number allows us to contact you if clarification is needed.
Step 2: Who will be Releasing and Receiving information? ☐ Named Individual, OR ☐ Named Organization	Write the full name of the person / agency that has your records. • Write "CompDrug" in this field if we are releasing your records. Write the full name of the person / agency that should receive your records. This could also be a spouse or another family member.
Step 3: What information do you want shared? Choose ONE option: ☐ All records, OR ☐ Choose all the documents you want shared	Most patients do not need to release their entire record. It's best practice to share only what's needed. • Check **"All records"** if you want everything on file. • Check the boxes for the **specific records** you want shared. Only the checked items will be shared. *If psychotherapy notes are required, they must be requested on a separate authorization.
Step 4: Dates of Records. Choose ONE option: ☐ All dates of service, OR ☐ Specific dates	Most patients do not need **all dates of service**. It's best practice to request only the dates you need. • Check **"All dates of service"** if you want everything on file. • If you only need certain visits, check **"Specific dates"** and write the start and end dates.
Step 5: Purpose of Disclosure. Choose ONE option: ☐ Choose one of the listed options	Check the option that best matches your reason for sharing the records or write in a reason for "Other". • Coordinating treatment is best used for short-term collaborations between providers • Continuity of Care is best used for sharing information to providers to provide consistent long-term care.
Step 6: Expiration of Consent. Choose ONE option: ☐ One year from today or 90 days after discharge, ☐ A specific date, event, or condition.	This determines **when your authorization ends**. Most patients choose the **standard expiration** option. • Check **"One year from today or 90 days after discharge"** for a standard timeframe. • Choose a **specific date, event, or condition** if you want the authorization to end sooner. For example, "End of Pregnancy"
Step 7: How Should Records Be Sent? Select all that apply: ☐ Secure fax ☐ Encrypted email	Choose how you want records delivered and provide the correct fax number or email address. • **Secure fax** is typically the fastest for offices and agencies. • **Encrypted email** is best for individuals and requires a working email address. Please make sure all contact information is accurate to avoid processing delays.
Step 8: Signature and Date ☐ Signature of patient or patient representative ☐ Date of Signature	**This form must be signed and dated by the patient.** If the patient cannot sign and a legal representative is signing instead (e.g., power of attorney, guardian), the representative must: • Sign and date the form • Print their name • Indicate their relationship to the patient
Step 9: Right to Revoke ☐ Revocation instructions ☐ Signature and Date	**Do NOT sign in this box unless you want to cancel your authorization.** • To revoke this authorization, you must submit a written request. Please send a copy of your signed revocation to Medical Records. • If you need a copy of your authorization, please contact Medical Registration or one of our Care Coordinators by calling (614) 224-4506.

CompDrug

Authorization for the Release of Health Information Records

I, _____ (Patient Name) , _____ (Date of Birth (MM/DD/YYYY)) , _____ (Telephone (xxx-xxx-xxxx)) authorize

Who will be Releasing and Receiving information? **Write in the name of both agencies.**

Disclosing Agency *(who is Releasing the information)*
Name of Person/Organization: _____

_____

Telephone: _____

Recipient *(who is Receiving the information)*
Name of Person/Organization: _____

_____

Telephone: _____

What information do you want shared? **Choose ALL that apply or write in the specific documents.**

☐ 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 Note *
☐ Referral Information
☐ Toxicology Results
☐ Treatment Status
☐ Other: _____

_____

Release information **ONLY** from these dates: ☐ All dates of service ☐ Specific Dates: Start _____ End _____

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.

What is the reason or purpose of the consent? **Choose ONE option or write in the name.**

☐ Coordinating Treatment
☐ Continuity of Care
☐ Legal Services
☐ Payment / Benefits
☐ Other: _____

When should this consent expire? **Choose ONE option.**

☐ In one year from the date of signature OR 90 days after discharge from CompDrug *(whichever comes first)*
☐ Upon a specific date, event, or condition as listed here: _____

How should the records be sent? **Choose ALL that apply and write in information.**

How will the records be sent: ☐ Secure Fax: _____ ((xxx) xxx-xxxx) ☐ Encrypted Email: _____ (name@email.com)

_____ (Signature) _____ (Date Signed (MM/DD/YYYY))

_____ (Printed Name *(if signed by authorized person)*) _____ (Relationship to Patient/Source of Authority)

*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.

_____ (Signature) _____ (Date (MM/DD/YYYY))

CompDrug – Medical Records
547 E 11th Avenue, Columbus, OH 43211
614-291-0118
MedicalRecords@compdrug.org

42 C.F.R. Part 2 Prohibits Unauthorized Use or Disclosure of These Records