MARYHAVEN®
Helping People Restore Their Lives®

Addiction Recovery and Mental Health Services

www.maryhaven.com

Per your request, attached is a copy of Maryhaven's Release of Information (ROI) form.
To ensure that your request is processed as timely as possible, please include the following:

Section I

- Client first and last name
- Client date of birth

Section II

- To whom records are being disclosed:
  - If records should be disclosed to an individual (i.e. emergency contact, family member), include the name of the individual to whom records should be disclosed.
  - If records should be disclosed to a provider, lawyer, caseworker, probation officer, disability claim adjudicator, etc., include the name of the agency, firm or treatment provider (ex. Ohio Health, FCCS) or treatment payer (ex. Medical Mutual, Buckeye).
- Where records should be sent (mailing address, email, or fax number)

Section III

- Reason for disclosure
- What information should be disclosed

Section IV

- Signature of client or authorized representative (ex. legal guardian)
- Date of signature

If any of the above items are not included on your ROI form, we will be unable to release the requested records.

Please return the completed ROI via fax at 614-448-4751or email to medicalrecords@maryhaven.com or mail to our main campus at:

ATTN: Maryhaven Medical Records
Department 1791 Alum Creek Drive
Columbus, OH 43207

Sincerely,

Maryhaven Medical Records Department
Phone: 614-445-8131
Fax: 614-448-4751

Maryhaven, Inc.
1791 Alum Creek Drive
Columbus, OH 43207-1757

Consent for Release of Part 2 Program (SUD Provider) Information

Phone: 614-445-8131
Fax: 614-448-4751

Fields marked with an asterisk (*) are required to be completed. ***Please*** provide the additional identifying information requested in Section I so that we can accurately respond to this request.

Section I

First Name*:	Middle Initial:	Last Name*:
Name at Time of Treatment (if different than above):		Social Security Number: (last 4 digits only) XXX-XX- ___________
Date of Birth (mm/dd/yyyy):	Phone:	Email:

I hereby authorize the disclosure of health information about the above individual as follows.

Section II

Disclosing Entity (Name of Holder of Part 2 Program Information) *: Maryhaven, Inc.	Fax Number: 614-448-4751

The information is to be provided to the following*:

- ☐ Named Individual (Ex: emergency contact, significant other): ____________________
- ☐ Named Third Party Payer: ____________________
- ☐ Named Entity (Ex: County Court, Children Services): ____________________

Recipient's Contact Information:

Phone Number:	Fax Number:	Email:	
Street Address:	City:	State:	Zip Code:

Section III

Reason for Disclosure*:

☐ Continuity of Care	☐ Inform Court	☐ Other: ____________
☐ Payment/Operations	☐ Compliance with Treatment	☐ Inform Social Services
☐ Disability Determination	☐ Court Proceeding	☐ Outcomes

Health Information to be Disclosed*:

☐ Presence in Treatment	☐ Clinical Evaluation/Assessment	☐ Test Results (Labs, Urinalysis, TB)
☐ Treatment Plans	☐ Medical Evaluation/Assessment	☐ Discharge Date/Type
☐ Diagnosis	☐ Psychiatric Evaluation/Assessment	☐ Other: ____________

Specify Time Period, if Desired:
Release only information from the period____________(mm/dd/yyyy) to____________(mm/dd/yyyy)

Section IV

This authorization will remain in effect until revoked or shall expire after one year from the date signed below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation by mail or hand delivery to the Maryhaven HIPAA Privacy Officer at 1791 Alum Creek Drive, Columbus, OH 43207, except to the extent that action has been taken in reliance on this authorization.

- Substance use disorder (SUD) records of Part 2 programs disclosed pursuant to this Consent are protected by federal regulations and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations. Any information disclosed pursuant to this Consent other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient.
- I might be denied services if I refuse to authorize disclosure of information for purposes of assessment, treatment, or payment relating to substance use disorder if refusal is permitted by state law. My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services.
- This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Print Name of Individual or Authorized Representative:	Relationship of Authorized Representative to Individual (if not self): (Authorized representative shall submit proof of authority to the disclosing entity) ☐ Parent ☐ Legal Guardian ☐ Other: ____________ ☐ Executor/Administrator ☐ Power of Attorney ☐	
Signature of Individual or Authorized Representative*:	Date*:	Time:

For administrative use only:

Method of Delivery: (e.g. mail, fax, email, verbal)	Date Released:

Updated: 08/2020