COBC℠
central ohio behavioral consulting

Authorization to Release Information

Date: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize Lindsay R. Sessor or Leigh Ann M. Shepherd at Central Ohio Behavioral Consulting, LLC to use or disclose information from my records during the term of this Authorization to the recipient(s) I have identified below.

Recipient(s):

1. _____
(Individual/Agency)

_____
(Address) (Phone number)

2. _____
(Individual/Agency)

_____
(Address) (Phone number)

3. _____
(Individual/Agency)

_____
(Address) (Phone number)

4. _____
(Individual/Agency)

_____
(Address) (Phone number)

5. _____
(Individual/Agency)

_____
(Address) (Phone number)

Information to be disclosed: This authorization permits the above provider to disclose the following information (check one):

- ❑ All of my treatment information that the provider has in her possession relating to any treatment received by me (i.e. consultation reports, progress notes, discharge summary, etc…).
- ❑ Only the following records or types of treatment information: (Insert dates of treatment, types of treatment or other designation) _____.

Term: This Authorization will remain in effect for one year from the date of this Authorization unless otherwise notified.

Redisclosure: I understand that once the provider listed above discloses my treatment information to the recipient(s) identified above, my provider cannot guarantee that the recipient(s) will not re-disclose my treatment information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my provider at the following address: P.O. Box 915, Marysville, Ohio 43040.
The revocation will be effective immediately upon my provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my provider the receipt of my written notice of revocation.

_____

Client Printed Name

_____ _____

Client Signature Date

If individual is unable to sign this Authorization, please complete the information below:

_____ _____

Name of Parent/Legal Guardian Legal Relationship

_____ _____

Signature of Parent/Legal Guardian Date

_____

Signature of Witness