Authorization to Use and Disclose Protected Health Information Form

I. I, Emilio Cruz, hereby voluntarily authorize the use and disclosure of protected health information ("PHI") deemed relevant to Delaware County Adult Court Services ("ACS") about me by signing this Authorization to Use and Disclose Protected Health Information Form ("Authorization").

This Authorization applies to the following individual, identified below by name, date of birth ("DOB"), and social security number, and authorizes the use and disclosure as specified herein:

Individual Name: DOB: Social Security #

II. The following agency(s) have my permission to exchange/give/receive/share/re-disclose information about me. (Please Check and/or Specify).

☐ ACS 117 N. Union Street Suite 317 Delaware, Ohio 43015	☐ Other(s) (Specify and Address)
☐ Other(s) (Specify and Address)	☐ Other(s) (Specify and Address)

III. **The purpose or need for this disclosure is:** (Please Check, Insert Case Number, and/or Specify)

☐ Legal Matter –Delaware County Common Pleas Court	☐ Other(s) (Specify)
☐ Other(s) (Specify)	☐ Other(s) (Specify)

IV. **The PHI to be disclosed from my health record includes the following**: (Please Check and/or Specify)

☐ Discharge Summary(ies)	☐ Psychiatric Evaluations	☐ Identifying Information
☐ Names of Agencies Providing Services	☐ Vocational assessments	☐ Psychological Assessment
☐ Emergency Room Treatment	☐ Disability Records	☐ Physician Orders
☐ Laboratory Reports	☐ Type of Services Received	☐ Medications Prescribed
☐ Billing Information	☐ Entire Medical Record	☐ Other (specify):

HIV/AIDS, Mental Health/Psychological, and Substance Use Information: (Please Check and Signature Required)

Information to Disclose	Signature

☐ HIV Test/AIDS-Related Health Information/Status	
☐ All Mental And Behavioral Health Information	
☐ Alcohol/Substance Use/Addiction Treatment Records	

Time Frame for PHI to be disclosed: (Please Insert Individual's DOB)

☐ Entire Time From Individual's DOB: Until Present Date

V. I understand that I may revoke this Authorization in writing submitted, at any time to the contact information listed below in this section, except to the extent that action has been taken in reliance on this Authorization. If this Authorization has not been revoked, I knowingly and voluntarily agree that this Authorization is to remain in effect until all criminal proceedings, including any incarceration term or probationary term, in Delaware County Case No. are completed or 365 days, whichever occurs last.

Written revocation must be submitted to the following person at the ACS:

Name: **Address**: 117 N. Union Street Suite 317 **City/State/Zip Code**: Delaware, Ohio 43015

VI. I understand that my alcohol and/or drug treatment records receive special protection under federal law (42 C.F.R. Part 2) and can only be re-disclosed as permitted by the federal regulations. I understand that my physical and mental health treatment records are protected by HIPAA but may be subject to re-disclosure if the recipient of my information is not subject to HIPAA.

This is a free and voluntary act by me. I understand that refusing to sign this form does not prohibit disclosure of my PHI that is otherwise permitted by law without my specific authorization or permission. Additionally, I have the right to receive a copy of this Authorization.

Individual Printed Name: ______________________________
(Or Person Authorized to Give Consent)

Individual Signature: ______________________________
(Or Person Authorized to Give Consent)

Relationship of Person if not the Individual: ______________________________

Date: ______/______/______

ACS Representative Printed Name: ______________________________

ACS Representative Signature: ______________________________

Date: ______/______/______