Release of Information

Delanie Isaacs, MA, LPCC
6058 Montgomery Road Cincinnati, Ohio 45213
513-739-9255, delanie.isaacs@delanieisaacs.hush.com

Client Name:
Date of Birth:
Address (street, city, state, zip):
I hereby authorize: Delanie Isaacs, LPCC
And
Name:
Address:
Phone:
Fax:
Relationship to client:
TO DISCLOSE TO AND COMMUNICATE TO ONE ANOTHER information contained in my patient records, including if any, alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA); social services records; psychological services records, including communications made by me to a mental health professional; and all information defined by statute and Ohio Department of Public Health Rules (Public Act 174, 1989) governing Human Immunodeficiency Virus (HIV), HIV Test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex (ARC), only under the conditions listed below (please circle):
ASSESSMENT/DIAGNOSIS
COMMUNICATION EXCHANGE
PSYCHOSOCIAL/COUNSELING
TREATMENT PLAN/CONTRACT
LAB RESULTS
ADMISSION/DISCHARGE DATA SET
SCHOOL/WORK RECORDS
SCHOOL/WORK SOCIAL
INVOLVEMENT
PROGRESS REPORTS
RECOVERY PLAN
DISCHARGE SUMMARY
DR. DISCHARGE SUMMARY
REAUTHORIZATION FORMS
OTHER PERTINENT INFORMATION (Specify):
Dates of Service:
PURPOSE AND NEED FOR SUCH DISCLOSURE:
CONTINUATION OF CARE
SCHOOL/WORK
REFERRAL FOLLOW-UP

FAMILY NOTIFICATION
RETURN TO SCHOOL/WORK
OTHER (Specify):
I understand that my medical record may contain reports, test results and notes that only a care provider can interpret. I understand and have been advised that I should contact my care provider regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Delanie Isaacs, LPCC, or counselors liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation. I understand that generally my treatment may not be conditioned on whether or not I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. This authorization is subject to a written revocation at any time except in those circumstances in which the counseling center has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. This authorization will automatically expire 12 months from the end of involvement in our programs or as specified in the revocation below.
Signature:
Date:
Witness:
Date:

REVOCATION (optional) – This authorization is revoked for the following specified dates, events, or conditions.