Central Ohio Counseling, Inc.
1035 Proprietors Rd.
Worthington, OH 43085
(p)614-785-1115 (f) 614-785-0095

Authorization to Release or Obtain Protected Health Information

Name:	Date of Request:
Address:	Date of Birth:
City/State/Zip	Phone #:

I authorize Central Ohio Counseling, Inc.(COC), 1035 Proprietors Rd., Worthington, OH 43085
COC Provider name_______________________________________

☐to release information to ☐to obtain information from ☐exchange information with

Name:____

Address:____

Phone:______________________________ Fax:___________________

Purpose of Authorization: ☐Coordination of Care ☐Personal Use ☐Legal
Other___________________________

I authorize the release of the following protected health information:
☐Entire Medical Record ☐Medical History, Initial Assessment, Progress Notes
☐Prescriptions ☐Labs Other:____

Method of release: ☐Paper(pt must pick up-fee may apply pursuant to AOC 3701.741) ☐Fax
☐Email--address____

I, the undersigned, authorize Central Ohio Counseling, Inc. to release health information as indicated/described above. I understand and acknowledge that the requested information may contain information regarding physical and mental illness, HIV or AIDS diagnosis, and/or drug/alcohol abuse, and psychotherapy notes.

Authorization and consent will expire one year from the signature date, unless revoked by me (or my legal representative) through written notice presented to Central Ohio Counseling, Inc.'s practice manager. Any revocation will not apply to information that has already been released in response to this authorization. All health information released electronically from Central Ohio Counseling, Inc. will be sent with encryption; I understand that the recipient of the information may not have encryption software when opening the information and my health information may no longer be protected.

___________________________________/______________________ ____/___/____
Signature of Patient/Patient's Personal Representative Printed Name Date

__________________________________/________________________ ____/___/_____
Signature of Witness Printed Name Date