MIKE LACINAK, LISW
9200 Montgomery Rd., Suite 14b, Cincinnati, OH 45242 or 6021 Beechmont Ave., Suite 2, Cincinnati, OH 45230
AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION

RE Client:______________________Date of Birth______________ SS #________ I, ________________________

Relationship to client_________ Hereby authorize ____________________ TO (circle one or both) RELEASE, OBTAIN MY MEDICAL/PSYCHIATRIC INFORMATION (circle one of both) TO/FROM:
Name: _________________________ Address: ____

Phone#______________________Fax#___________________ Dates of treatment: ____________________________

This release is includes but is not limited to information concerning Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus) drug abuse or drug related conditions and/or psychological and/or psychiatric conditions or permit review of same, provided however that such release is limited specifically to material of the following nature and extent:

I authorize the following information to be released:
__ Summary of Treatment __ Progress Notes __Diagnoses __ Treatment Plan __ Diagnostic Assessment
__Treatment Recommendations ____Attendance records Only __Progress Report on Treatment
Other (specify) ____

This authorization also includes release of records relating to:*If this section does not apply check here* ___
__Diagnosis and/or treatment for alcohol and/or drug abuse
__Redisclosure/Re-release of Information*(specify) ____

Disclosure is for the following purpose or need:
__Individual's request __School education __Reimbursement __Assessment __Continuity of Care
__Treatment Planning ___Aiding in a referral __SSI/Disability Claim __Legal
__Other (specify):____

FORM IN WHICH INFORMATION SHOULD BE RELEASED:
____ verbal ____ photocopied ____ written ____ other

THE PURPOSE FOR SUCH DISCLOSURE IS:
_ To permit continuity of care. _ To permit case management (including reimbursement determinations) and processing of benefit claims.
_ To enable my employer to make a determination on my employment status (including disability leave).
_ Other (specify):____
ANY ADDITIONAL RESTRICTIONS, EXCEPTIONS, OR EXCLUSIONS, IF ANY, OF INFORMATION RELEASED: __ None

This authorization shall remain in effect for 6 months unless an earlier or later date/condition/event is specified here: ____________________________
I understand that I have the right to shorten or lengthen the authorization at any time. I understand that I have the right to revoke this authorization at any time, and that the revocation will be effective except to the extent that Mike Lacinak, LISW has already taken action in reliance upon my authorization. A written or oral statement that I want to change or revoke my authorization should be given to Mike Lacinak LISW.

____ _____________________________________
Signature of patient/client **Signature of parent, guardian, conservator or authorized representative (when required)**

If this authorization has been signed by a representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here: ____

____ _____________________________________
Date **Witness**

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.

If Re-Release of Information is checked (above at*), I understand that I am authorizing the release of information from another source.

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by this rule. My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enrollment in a health plan.
OFFICE USE ONLY

STAFF PERSON FACILITATING THIS RELEASE______________________ **DATE INFORMATION RELEASED** ________________
COPYOF AUTHORIZATION TO INDIVIDUAL? __ DECINED: __ A FAX OF THIS SIGNED DOCUMENT MAY BE ACCEPTED IN LIEU OF THE ORIGINAL