Ohio HIPAA Privacy Authorization Form and Consent to Treat

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization and Consent I authorize **Buckeye Therapy Services, LLC** (healthcare provider) to provide Occupational Therapy Evaluation and Treatment (including direct one to one and Telehealth services) to the Following Client:

Name: _____DOB: _____

As necessary to provide those services, I also authorize use and disclose the protected health information described below to/from:

_____individual/agency

_____individual/agency

_____individual/agency

2. Effective Period This authorization for treatment and release of information covers the period of healthcare from:

a. ☐ _____ .(Referral Date) **OR**

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR b. □ I authorize the release of my complete health record with the exception of the following information: □ Mental health records □ Communicable diseases (including HIV and AIDS) □ Alcohol/drug abuse treatment □ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until discharge from program (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Legal guardian or representative_____

_____

Printed name of Legal guardian or representative and his or her relationship to client

Date : _____