Print Form

Authorization to Obtain and/or Disclose Information

I, _____SSN:_____

Authorize the following entities:

Entity 1:	**Entity 2:**
CompDrug Inc. **547 East 11th Ave.** **Columbus, Ohio 43211** **Phone: 614-224-4506** **Fax: 614-291-0118**	

- To obtain and/or disclose the following information with to/from each other (Please be specific):

-For the Dates of Service between: _____ And _____

-For the explicit purpose of:

-This Authorization Expires on the following date and/or when the following condition is met:

(Unless otherwise restricted above, this Authorization will automatically expire one year after discharge)

I hereby AUTHORIZE the named entities to obtain and/or disclose the information itemized in this document.

Client/Patient Signature and Date: _____

Staff/Witness Signature and Date: _____

Prohibition on Redisclosure: As required by section 2:32(2) Prohibition of Redisclosure Rules: 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 the 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.I understand that the information is protected by law and may not be redisclosed without my written authorization or as otherwise permitted by law; however, I understand that CompDrug cannot control the recipient's use of the information and that protected health information may be redisclosed by the recipient. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining authorization to disclose if such conditioning is prohibited by the HIPAA Privacy Rule or other governing law.

REVOCATION (I understand that I may revoke this Authorization at any time, except to the extent that action has been taken in reliance on it. Revocation must be in writing signed and dated by me. Upon revocation of this Authorization, further release of information hereunder shall cease immediately.)

I hereby REVOKE this authorization of the named entities to obtain and/or disclose the information itemized in this document.

Client/Patient Signature and Date:_____