The CAMHP Foundation
3237 Ormond Road
Cleveland, OH 44118
Office: (216) 501-1730

Authorization to Release/Obtain Information

Transmitting and Acceptance of Forms Relating to Consumers Economic Life

The Following Are Authorized To: ☐ Release/Disclose and(or) ☐Obtain

Organization and/or individual providing the information:	Organization and/or individual receiving the information:
Address	Address
City State Zip	City State Zip
Phone Fax	Phone Fax

Reason: ☐ Solving economic ☐ Other: _____

Type of Information to Be Released/Obtained:

☐ Lease ☐Internet/Cable Bills ☐Utility Bills ☐ Debt Information
☐Identification Documents ☐Social Security Information ☐ Credit Score
☐ Communication between Social Security and other financial institutions
☐ Employees ☐1099 Contractor
☐ Other:_____

Amount of Information to be Released/Disclosed:

☐Information covering previous 6 months
☐Information related to current economic issue
☐Other amount of information: _____

_____

Organization and/or individual providing the information

I _____ have requested CAMHP Foundation to assist me in resolving my current economic issue. This current economic issue has directly affected my ability to continue living in my residence, pay my utilities, purchase food, afford transportation, and provide other basic needs for myself.

I live below 200% poverty, and this is proven with my receipt of 2 of the following:

☐ Food & Cash Assistance (SNAP) ☐ TANF ☐ Housing & Utility Assistance Programs (HUD)
☐ SSI – Social Security ☐ Medicaid/ CHIP ☐Other: _____

Understand that this information will be disclosed from records protected by federal confidentiality rules 42 C.F.R (Part 2). The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom 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 information to criminally investigate or prosecute any alcohol or drug abuse client.

Understand that I may see and copy the information described on this form if I ask for it. I also understand that the provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. The health care providers listed above will not receive financial or in-kind compensation in exchange for using or disclosing my health care information.

This consent is subject to revocation at any time except in cases where information has already been released. Revocation applies to that date forward and not to information already shared. If not revoked, this consent will expire 180 days from the date of the authorization written below.

If not previously shortened, lengthened or revoked, this authorization will expire on: _____

Signature of Client:	Printed Name:	Date:
_____	_____	_____
Signature of Legal Guardian:	Printed Name:	Date:
_____	_____	_____
Signature of Witness:	Printed Name:	Date:
_____	_____	_____

A copy of this authorization shall have the same force and legal effect as the original.

<u>Revocation of Authorization for Release of Information</u>

As of the date and time noted below, I hereby revoke permission for Danielle Dronet/Center for Advanced Mental Health Practice to further release information to the above-noted person, except to the extent the program has already acted in reliance upon it.

_____	_____	_____	_____
Client/Legal Guardian	Date/Time	Witness Signature	Date/Time