Clinic Security & Logistics, Inc., dba FULL CIRCLE RECOVERY SERVICES
20 Livingston Ave., Dayton, OH 45403
Phone: (800) 829-5461 Fax: (937) 813-2757

Authorization to Release & Exchange Information

I, _____ authorize Clinic Security & Logistics, dba Full Circle Recovery Services to release to, obtain from, or exchange with the organization indicated below information concerning treatment of the client named below. This authorization includes *electronic, oral and/or written communication.*

CLIENT INFORMATION	PERSON/AGENCY RELEASING TO:
Name:	Person/Agency Name:
SS#:	Address:
DOB:	City/State/Zip Code:
Address:	Phone/Cell:
City/State/Zip Code:	Fax:/Email:

The purpose of the release is to obtain/disclose:

- ☐ Continuity of Care
- ☐ Emergency Contact/General Updates
- ☐ Court Services/Legal Purposes/
- ☐ Disability Claim
- ☐ Other _____

Types of information to be obtained/disclosed:

- ☐ Presence In Treatment
- ☐ Progress In Treatment
- ☐ Treatment Plans
- ☐ Psychological Assessment
- ☐ Psychiatric History & Assessment
- ☐ Results of Physical Exam
- ☐ Medical History/Current Status
- ☐ Biopsychosocial Assessment
- ☐ Laboratory Test Results
- ☐ Employment Information
- ☐ Legal Status
- ☐ Family Information
- ☐ Aftercare Recommendations
- ☐ Discharge Planning
- ☐ Discharge Summary
- ☐ Other _____

_____ _____

Person/Agency ROI is assigned to Date

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HIPAA

I understand that my records are protected under Federal Regulations (42 CFR Part 2) and the Health Insurance Portability Accountability Act (HIPAA), 45 CFR, pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically one year from the date signed, otherwise unless specified below. I understand that generally Clinic Security & Logistics, Inc. may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances support or collateral investigations is a key component and we may not be able to meet your needs without the key contacts involvement. I understand I am entitled to a copy of this document in its complete form.

This authorization shall remain valid until: _____ (not to exceed one year)

Client Signature:	Date:
Client Legal Guardian, Relationship to Client	Date:
Clinic Security & Logistic Staff Signature:	Date:

I, _____ revoke this release on _____
Date of revocation

Please submit completed form to:
info@OhioFullCircle.com - or-
20 Livingston Ave., Dayton, OH 45403

_____ _____
Person/Agency ROI is assigned to Date