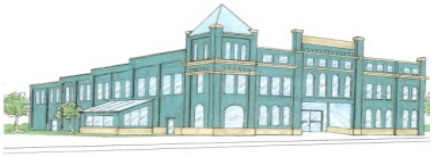

Paramount Development Association
Behavioral Health Care Agency
1818 W. Third Street, Dayton, Ohio 45417
Exe. Director: Dr. Margo Willis, 937-263-8176

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD
(Also known as Protected Health Information)

PATIENT NAME: _____ Date of Birth _____

Address(Mailing) _____
Phone: _____

I authorize Paramount Development Association Behavioral Health Care Agency to use or disclose information from my mental health records, which may include information about Psychiatric Diagnosis and treatment, to the following individual:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

Date(s) of Treatment: _____

Information to be released (Please Describe) _____

Purpose of Disclosure: _____

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Paramount Development Association at the address indicated above. In writing, and this authorization will cease to be effective on the notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse, treatment information, and mental health information.

4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

5. My health care and payment for my health care at Paramount Development Association Behavioral Health Care Agency will not be affected if I do not sign this form.
6. I understand that that I can request a copy of this form after I sign it.
7. I understand that in compliance with Paramount Development Association Behavioral Health general statute, I will pay a fee of $.55 per page.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____
Signature of Client Date

OR

_____
Relationship to Patient

_____ _____
Parent Legal Guardian/ Authorized Person Date

_____ _____
Signature of Client Date

OR

_____
Relationship to Patient

_____ _____
Parent Legal Guardian/ Authorized Person Date