MATRIX

Authorization to Release Protected Information
Employer Referral

Employee's Name _____ Date of Birth _____

I authorize Matrix to secure/release the following information relevant to my case:

_____ treatment plan

_____ substance abuse assessment results

_____ dates of service

_____ discharge summary

_____ client progress via telephone

_____ Other (specify) _____

_____

_____ Release to _____ Receive from _____Exchange with

Name _____ Title _____

Address_____

Phone _____ Fax _____

Human Resources contact (If different from above): _____

Phone _____

Fax _____

I am requesting Matrix to release this information for the following reasons:

____ At my request

____ Other _____

This authorization shall remain in effect for one year, unless revoked in writing prior to that time.

I have the right to revoke this authorization, in writing, at any time, by sending such written notification to Matrix at 2 Easton Oval, Suite 450, Columbus, OH 43219. However, my revocation will not be effective to the extent that Matrix has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. A copy or facsimile transmission of the original of this authorization shall be treated with the same force and effect as the original hereof.

I understand that Matrix generally may not condition psychological services upon my signing an authorization unless psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule._

_____ Date _____

Signature of Patient

Phone: 614-475-9500/ 800-886-1171
Fax: 614-475-9821

2 Easton Oval, Suite 450
Columbus, OH 43219