CHARDON MUNICIPAL COURT
ATTN: PROBATION DEPARTMENT
111 WATER STREET ♦ CHARDON, OH 44024
PHONE: 440-286-2649 ♦ FAX: 440-279-0904
EMAIL: muniprobation@geauga.oh.gov

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFO:

- ☐ **TO PROBATION, CHARDON MUNICIPAL COURT**
- ☐ **FROM PROBATION, CHARDON MUNICIPAL COURT**

NAME OF HEALTH CARE PROVIDER _____

DOCTOR, FACILITY REPRESENTATIVE OR PROVIDER NAME _____

STREET ADDRESS _____

PHONE NUMBER _____ FAX NUMBER _____

CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____

THIS AUTHORIZATION IS IN EFFECT UNTIL MY TERMINATION FROM PROBATION BY CHARDON MUNICIPAL COURT, OR EARLIER REVOCATION BY ME.

THE PURPOSE OF DISCLOSURE IS FOR: _____

CHECK OFF THE INDIVIDUAL AREAS FOR RELEASE BELOW:

	ADMISSION NOTIFICATION		PHONE CONTACT
	LAB REPORTS (DRUG & ALCOHOL SCREENS)		DISCHARGE SUMMARY
	72-HOUR EVALUATION & ASSESSMENT		PROGRESS IN TREATMENT
	HISTORY & TREATMENT PLAN		ALCOHOL/DRUG EVALUATION/ASSESSMENT
	PROGRESS REPORTS		CURRENT MEDICATION LIST
	PSYCHOLOGICAL/PSYCHIATRIC EVALUATION		OTHER (SPECIFY)
	FULL COMPREHENSIVE ASSESSMENT		OTHER (SPECIFY)

I realize that my records may be protected under federal and state confidentiality regulations and cannot be released or disclosed without my written permission. Any health care (or payment for care) will NOT be affected by whether I sign this authorization. Once my confidential information is released, I understand that further disclosure of my health care information by the Probation Officer or the Chardon Municipal Court will no longer be protected by law. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses. I also understand that I may revoke this authorization at any time except to the extent that action has occurred prior to revocation. I acknowledge that my revocation of this release may violate a condition of my probation if I am required to provide or authorize the release of the above information or records.

DATE: _____ PATIENT'S SIGNATURE: _____

D.O.B.: _____ PATIENT'S PRINTED NAME: _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE # _____

WITNESS: _____ RELATIONSHIP: _____