Ohio Psychiatric Physicians Association

Authorization for Release of Information

I, _____ , hereby authorize _____
(facility/therapist)

_____ to release any and all records and information relating to my psychiatric condition and any mental health treatment I have received from you or others, including records or information in your possession which have been provided to you by other treatment providers to the Ethics Committee, Ohio Psychiatric Physicians Association, 3510 Snouffer Rd., Ste. 101, Columbus, OH 43235 for the purpose of investigating and making decisions about my complaint against

_____ .
(OPPA Member)

This consent is valid until the investigation and any appeals of any findings thereof have been completed by the Ethics Committee and all reviewing bodies thereof.

I understand that I may revoke this consent at any time and that the above-named person authorized to receive this information has the right to inspect and copy the information to be disclosed.

It has been explained to me that if I refuse to consent to this release of information, the Ohio Psychiatric Physicians Association and the American Psychiatric Association will be unable to investigate my complaint and take action thereon.

_____ _____
(Minor recipient, under 18 years) (Signature)

_____ _____
(Witness) (Date)

_____ _____
(Date) If signature is not of recipient, indicate legal relationship to recipient and legal basis on which consent is given for recipient

_____
Parent/Guardian
(if minor recipient)