New Horizons Mental Health Services
INFORMED CONSENT FOR SHARING INFORMATION

Today's Date:

Client Name:

Date of Birth:

ACKNOWLEDGMENT OF CONSENT FOR SHARING INFORMATION WITH THE STATE OF OHIO

1) I agree to CONSENT TO SHARING INFORMATION FOR:

   ☐ Myself ☐ My child ☐ The person for whom I am legal guardian

2) I give consent for New Horizons Mental Health Services to share the Protected Health Information for treatment, payment and health care operations with the State of Ohio for the purpose of evaluation relating to state and federal funds expended for such purposes.

3) I acknowledge this consent is voluntary.

4) I further acknowledge that I may revoke, in writing, this consent at any time; except to the extent that action based on this consent has already been taken.

______________________________ ____________

Client/Guardian Signature Date

______________________________ ____________

Witness/Facilitator Signature Date

REVOCATION OF CONSENT FOR SHARING INFORMATION WITH THE STATE OF OHIO

I wish to revoke my consent.

____ ____________________

Client/Guardian Signature Date

____ ____________________

Witness Signature Date