Promoting wellness and recovery

John R. Kasich, Governor • Tracy J. Plouck, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

Statement of Conflict of Interest

Directions: This form is for use by any person interested in submitting a statement of Conflict of Interest against an Ohio Certified Peer Recovery Supporter.

- Include copies of any relevant documentation
- Complete and sign the release included.
- Please submit a signed release of information signed by the client so OhioMHAS can access to client files, if applicable.
- Include names, addresses and telephone numbers of any individuals who have knowledge of the situation.

1. Statement Against:

Name: _____
(Certified Ohio Peer Recovery Supporter)

Employer/Name of Practice:_____

Address:_____

_____

Telephone #: _____ Email:_____

Certificate #: (If known) _____

2. Statement Filed By:

Name _____

_____

Address: _____

_____

Telephone #: _____ Fax #: _____

Email:_____

3. **Action You Have Taken:**

Have you voiced your concern to leadership at your agency? If yes, what was the outcome?

_____

_____

_____

_____

4. **List Names, Addresses and Phone numbers of any witnesses who either have knowledge of the conflict of interest or may have other relevant information**. Briefly describe the information each individual possesses:

_____

_____

_____

_____

_____
_____
_____
_____

5. **Statement:**

- **Describe the conflict of interest, which you believe to be a violation.** Please include the sequence of events surrounding the conflict of interest, date of occurrence, and attach any information that you think will help substantiate your concern. Attach statement if additional space is needed. All concerns must involve points identified on the Certified Ohio Peer Recovery Supporter Pledge. 5122-29-15, or5122-29-15.1.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

6. **Signature**

Are you willing to give a sworn statement? _____

Did you sign and attach Release of Information Authorization? _____

Investigations are confidential, however, statement provider acknowledges that in some cases, based on the nature of the statement it may be necessary to reveal your name. By signing this statement, I assert that all information is true to the best of my knowledge. I also acknowledge that I have received and read the Investigation/Conflict of Interest Information of Ohio Mental Health and Addiction Services:

_____ _____

(Signature of Individual Making Statement) (Date)

Authorization for Release of Information

1. Name:_____
2. Date of Birth:_____
3. I authorize: (Practitioner/Agency Name) _____
To release information to:

Community Recovery Initiatives Administrator
The State of Ohio Department of Mental Health and Addiction Services
30 East Broad Street, 36th Floor
Columbus, OH 43215
Telephone (614) 466-2596 Fax (614) 644-1502

4. Date(s) of service (Month, Day & Year to the best of your knowledge):_____

5. **Specific information to be released** (check all that apply):

___ History & Physical Exam
___ Psychiatric/Mental Health Evaluations
___ Treatment Plan
___ Progress Reports
___ Discharge Plan
___ 3rd Party Correspondence
___ Consent for Treatment
___ Custody/Parenting Documentation
___ Correspondence with Attorneys/GAL/Courts
___ Other (specify): _____

6. Reason for disclosure: _____

7. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. **This authorization (unless revoked) expires one year from the date provided below.**

Signature: _____ Date: _____
(Patient/Parent/Legal Guardian)

Revocation of Release of Information:
I hereby withdraw my consent for this release of information:
Signature: _____ Date: _____
(Patient/Parent/Legal Guardian)