AUTHORIZATION FOR RELEASE OF INFORMATION

The undersigned hereby authorizes: _____ to release information from the medical records of:

_____
name of client

_____ _____
date of birth social security number

_____
dates of treatment

- I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of psychiatric disorders/mental health, drug and/or alcohol use, HIV/AIDS or sexually transmitted diseases.
- If there is information pertaining to psychiatric disorders/mental health, drug and/or alcohol use, HIV/AIDS or sexually transmitted diseases in my medical record, you are specifically authorized to release it.
- I am giving this consent voluntarily and have been informed of the specific type of information that has been requested.
- Information may be released in written or verbal format. Benefits and disadvantages of releasing information have been explained to me.
- I understand that provision of service does not depend on my decision concerning the release of information.

TIME LIMITATION OF RELEASE: This authorization expires 60 days from the date of signature, or _____.
I understand this authorization is subject to revocation at any time except to the extent that information has already been released based upon it. I can revoke this authorization by signing the bottom of this form.

PROHIBITION ON REDISCLOSURE: According to 45 CFR 164.508 c2Ciii health information may be redisclosed by the recipient. However, pursuant to KRS 304.17A-555, Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure any Protected Health Information may not be used and/or shared by the recipient of said information unless specific, written consent for redisclosure is authorized by the person to whom it pertains. Additionally, Federal Regulations 42 CFR, Part 2 prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Information is to be released to: name of person/facility: _____

address: _____ _____ _____ _____
street city state zip code

PLEASE CHECK INFORMATION REQUESTED

☐ intake/admission summary ☐ psychological assessment ☐ treatment notes
☐ termination/discharge summary ☐ other (specify): _____

I understand that the purpose of this disclosure is for: ☐ use in future treatment ☐ other
_____

_____ _____
signature of client/patient date

_____ _____ _____
signature of client's/patient's legal representative/guardian relationship date

_____ _____
witness date

*****I wish to revoke the above authorization*****

_____ _____
signature of client/patient date