AUTHORIZATION FOR RELEASE OF INFORMATION

_____ _____
Name Social Security Number

_____ _____
Birth Date Dates of Treatment Service

The undersigned hereby authorizes the release of information from the Medical Record of the above-named individual (check appropriate sections):
__ From / __ To:

RHBH- Danville
975 Hustonville Rd., Suite 7
Danville, KY 40422

RHBH- Georgetown
751 Sloan Dr., Suite 1&2
Georgetown, KY 40324

RHBH- Hillview
1191 Hillview Blvd., Suite 2 #2
Louisville, KY 40229

__ From / __ To:

Agency/Contact Name/Relationship: _____
Address: _____
Phone #/Fax #: _____

Purpose of Release:
_____

I understand that I may inspect or copy my Protected Health Information prior to its use or disclosure.
I understand that I may refuse to sign this authorization and that the provision of services is not contingent on obtaining this authorization unless it will interfere with the receipt or payment of substance abuse/behavioral health services.

Type of Released Information:

__ Admission Assessment __ Psychological Evaluation __ Drug Abuse/Alcohol Abuse Treatment Information __ Psychiatric Evaluation __ Progress Notes __ Treatment Information including HIV infection or AIDS as well as tests for HIV __ Medication __ Case Management Documentation __ Treatment Plans __ History & Physical __ Discharge Summary __ Psychosocial __ Laboratory Tests __ Other (specify):
_____
_____

TIME LIMITATION ON RELEASE: This authorization expires in 1 year or on the following date, event, or condition: _____. I understand that I may revoke this authorization in writing to the Clinical Director and/or Health Information Administrator at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it or if the authorization was obtained for the purpose of obtaining reimbursement from payor sources.

PROHIBITION ON REDISCLOSURE:

- *The following applies to clients who received alcohol or drug services. Check if applicable.* _____

This information has been disclosed to you from records whose confidentiality is protected by Federal Law (42 U.S.C. §§ 290dd-22.). Federal Regulations (42 C.F.R. Part 2) prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. The 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.

- *The following applies to clients who have not received any alcohol or drug services. Check if applicable.* ____

I understand that pursuant to KRS 304.17A-555: Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure, my protected health information, used and/or shared under this authorization may not be shared again by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the redisclosure.

_____ _____
Client's Signature Date

_____ _____
Client's Printed Full Name Date

_____ _____
Witness Date

*Should client revoke authorization at any time, attach their written revocation and instruct client to sign and date below:

_____ _____
Client's Signature Date