

FOUR RIVERS BEHAVIORAL HEALTH AUTHORIZATION FOR RELEASE OF INFORMATION

Name _____

S.S. No. / I.D. No. _____

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 box(es)):

FROM _____ TO _____

FOUR RIVERS BEHAVIORAL HEALTH

TO _____ FROM _____

FOUR RIVERS BEHAVIORAL HEALTH

TYPE OF INFORMATION TO BE RELEASED:

- Admission Summary Progress Notes Treatment Plans Laboratory Tests Psycho-Social
 Psychological Eval. Psychiatric Eval. Current Medical Status Discharge Summary TX Summary
 Drug / Alcohol Diagnosis, Treatment and/or Referral Information
 Treatment Information which may include Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndrome (AIDS) or Tests for HIV
 Other (specify) _____

PURPOSE FOR RELEASE: _____

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PROHIBITION ON REDISCULOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Law (42 U.S.C. 290dd-22.) Federal and State Regulations (42 C.F.R. Part 2) (KRS 304) 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 and KRS 304. 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. I am giving this consent voluntarily and have been informed of the specific type of information that has been requested and the benefits and disadvantages of releasing information that has been explained to me. I also understand that the provision of services is not contingent on my decision concerning this release of information.

TIME LIMITATION OF RELEASE: This authorization expires on ____/____/____ (not to exceed one year). I understand this release is subject to revocation in writing at any time except to the extent that the program which is to make the disclosure has already taken action in reliance to it. I also understand that if the person(s) or entity(ies) that receive the information is not a health care provider or plan covered by general privacy regulations, the information received may be re-disclosed and is no longer protected by these regulations. I understand that I may inspect or request copies with any information disclosed by this restriction.

Signature of Consumer Date

Signature of Consumer's Parent / Legal Guardian Date

Witness Date

* * * * *

Revocation of Release: _____ Date Revoked _____
Signature of Consumer, Parent, Guardian

*****FOR OFFICE USE ONLY*****

Specific information released: _____

Date information was released: _____

Signature of staff releasing information: _____

Free Copy: Yes No Charge: \$ _____

Important Information:

1. I understand that the provider cannot guarantee that the recipient will not redisclose my health information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
2. I understand that, except when I am receiving research related treatment or receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Four Rivers Behavioral Health.
3. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by Four Rivers Behavioral Health in reliance upon this authorization before written notice of revocation is received by them. I further understand that I must provide any notice of revocation to the Site Administrator of the office from which I am receiving service.