NorthKey Community Care

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____, ___________________________, ________________________
(Full Name of Client) (SSN/ID #) (Date of Birth)

I authorize and give this consent voluntarily. I have been informed of the specific type of information that is being requested/released. I also understand that refusal to sign this authorization in no way affects my treatment, payment or eligibility for benefits. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of any health information, I can contact the Privacy Officer at NorthKey Community Care.

COMPLETE LEFT TO RIGHT (check appropriate boxes):

☐ **FROM**
______**NorthKey Community Care**_________
___________Fax 859-261-1403___________

☐ **FROM** (Full name and address of individual/agency)
____
____
____
____

☐ **TO**
_____**NorthKey Community Care**_________
____ _ ______Fax 859-261-1403___________

☐ **TO** (Full name and address of individual/agency)

Release is for: ___Outpatient ___Inpatient ___Both

*******THESE FOUR SECTIONS *REQUIRE* AN ANSWER*******

TYPE OF INFORMATION TO BE RELEASED: CHECK ALL THAT APPLY

___All
___ Admission Summary
___ Psychiatric Evaluation
___ Psychological Evaluation
___ Current Medical Status
___ Medication List
___ Progress Notes
___ Treatment Plans
___ Discharge Summary
___ Billing Information
___Other (must specify):
____
____

PURPOSE FOR RELEASE

___ Report client progress
___ To obtain collateral information in treatment of this client
___ Verify client attendance
___ Legal
___ Accompany client to appointments

___ Crisis Referral for SCL/Case Mgmt Providers of KY: For list of providers: HYPERLINK "http://dbhdid.ky.gov/ddid/scl forms-cm.aspx" http://dbhdid.ky.gov/ddid/scl forms-cm.aspx

___ Other (must specify):
____
____
____

TIME FRAME (AMOUNT) OF INFORMATION TO BE RELEASED

___ Information covering the most recent admission

___ Information covering the previous three months

___ Information from beginning to present

___ Other time frames (must specify):
____
____
____

SUBSTANCE/HIV/STD INFORMATION TO BE RELEASED (*You must choose an answer*)

___ All Substance/HIV/STD information
___ Treatment Information which may include Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndrome (AIDS), or Tests for HIV
___ Drug, Alcohol Assessments ___ Drug, Alcohol Treatment Notes ___ Sexually Transmitted Diseases Other: ________________________________

___ NONE/ I DO NOT WISH TO HAVE ANY INFORMATION FROM THIS SECTION RELEASED

TIME LIMITATION OF RELEASE: This release will expire one year from the date signed unless otherwise indicated here ____________________.

______________________________________ ______________
Signature of Client Date

______________________________________ ______________
Signature of Client's Parent/Legal Guardian Date

Witness Date

PROHIBITION ON REDISCLOSURE:

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a client as having or having had a substance use disorder

Please see back

federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

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STAFF INSTRUCTIONS: All INFORMATION ON THIS PAPER must be entered electronically as soon as possible. This form must be scanned/attached to the electronic visit to have client signature with visit.

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REVOCATION OF RELEASE:

This release is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. For the revocation of this authorization to be valid the revocation must be IN WRITING, a proper photo I.D. provided and signed.

___ RELEASE IS BEING REVOKED. *If client is REVOKING THIS RELEASE, you must complete a "RELEASE REVOCATION" visit, proper ID must be given and the Director of Medical Records must be notified.*

Signature of Client Date

Signature of Client's Parent/Legal Guardian Date

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