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 859-534-2627

☐ **TO**
NorthKey Community Care
Fax 859-534-2627

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

☐ **FROM** (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	PURPOSE FOR RELEASE	TIME FRAME (AMOUNT) OF INFORMATION TO BE RELEASED
___All ___ Admission Summary ___ Psychiatric Evaluation ___ Psychological Evaluation ___ Current Medical Status ___ Medication List ___ Progress Notes ___ Treatment Plans ___ Discharge Summary ___ Billing Information ___Other (must specify): _____ _____	___ 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: http://dbhdid.ky.gov/ddid/scl forms-cm.aspx ___ Other (must specify): _____	___ 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 either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The 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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