NorthKey Community Care

AUTHORIZATION FOR RELEASE OF INFORMATION

_____,_____ ,_____

Client Name **DOB** **SSN**

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 the disclosure of any health information, I can contact the HIPAA Privacy Officer at NorthKey Community Care.

___ I authorize the disclosure/mutual exchange of my health information between NorthKey and the person/entity listed below:

Name of Person/Entity: _____Phone: _____

Address: _____ Fax: _____

TYPE OF INFORMATION TO BE RELEASED: CHECK ALL THAT APPLY OR CHOOSE ALL	PURPOSE FOR RELEASE
____All Types of Information ___ Billing Information ___ Current Medical Status ___ Discharge Summary ___ Medication List ___ Progress Notes ___ Psychiatric Evaluation ___ Psychological Evaluation ___ Treatment Plan ____Other (must specify) _____ _____	___ Accompany client to appointments ___ Continuity of Care ___ Legal ___ Report client progress ___ Verify client attendance ___ 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) _____ _____

Date(s) of Service Requested: From: _____ To: _____

Substance Use/HIV/AIDS/STD Information:

I understand the information to be released may include information about behavioral or mental health services and treatment for alcohol and drug use. It may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). *Unless checked below, I consent to the release of this type of information.*

___ I do not authorize the release of this type of information.

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

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.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

NKCC – PF 106

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