NORTHKEY COMMUNITY CARE
AUTHORIZATION FOR THE RELEASE OF INFORMATION

I authorize and give this consent voluntarily for the mutual exchange of information between NorthKey Community Care and the below named person/entity. 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.

Client Information

Client Name: _____ DOB: _____ SSN: _____

Name Parent/Legal Guardian: _____ Phone: _____

Client/Parent/Legal Guardian Email Address: _____

Note: Failure to fill out this form in its entirety will void this document.

Release to:

Name: _____ Organization: _____

Street Address: _____

City/State: _____ _____Zip Code: _____ Phone: _____

Fax: _____ Email:_____

Purpose

Records are to be released for the following purpose:

__ Continuity of Care __ Report client progress Other: _____
__ Disability/SSI __ Verify Attendance
__ Personal __ Legal/Court
__ Crisis Referral for SCL Case Mgmt. Providers of KY: For a list of Providers: http://dbhdid.ky.gov/ddid/sclforms-cm.aspx

Information to Release

Dates of Services Requested: The last 2 years of active services will be provided **OR** I am requesting:

__ Services from beginning to present (entire medical record)

__ Specific dates:_____

__Not requesting records at this time. Release to remain on file for continuity of care.

Type of information to be released: __All __Progress Notes __Discharge Summary __Evals __Tx Plan __Med List __Dx __Other_____

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.*

Client/Parent/Legal Guardian

Unless otherwise revoked, this authorization will expire one (1) year from the date signed or on the following date: _____.

Unless otherwise noted, records documented after the signature date below will be released upon verbal; or written request of the client/parent/legal guardian for up to one year from the date of signature.

I, the undersigned hereby authorize North Key Community Care to use and disclose information from my record as specified above.

Signature of Client: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

Disclosure/Revocation

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 acted in reliance on it. For the revocation of this authorization to be valid, the revocation must be in writing.