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| AUTHORIZATION FOR RELEASE OF INFORMATION |
| 1. The undersigned hereby request and/or authorize:

NewSong Counseling Center 205 N. Maysville Street, Mt. Sterling, KY 40353 |
|  ❑ to release medical records ❑ receive medical records ❑ both release and receive medical records |
| Name: | SS# |
| Birth Date: / / |  |
| Address:  | Phone: |
| City: |  |
| State: Zip:  |  |
| 1. Communicating Person(s) or Agency(s): Unless you are providing treatment to the client, you must specify name of an individual NOT a law firm, court, office, etc. (If additional space is needed, add individual names on Addendum A.) Check the “Yes” box if additional names are included on Addendum A or “No” if there are no additional names ❑Yes ❑No

Name of Person or Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Information to be released – check ‘yes’ or ‘no’ AND initial.(May include substance use disorder records, if applicable)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Yes | No | InformationAuthorized to Release | Initials |  | Yes | No | InformationAuthorized to Release | Initials |
|  |  | Major Evaluations |  |  |  |  | Medications |  |
|  |  | Treatment Plans |  |  |  |  | Progress Notes |  |
|  |  | Appointment History |  |  |  |  | Other: |  |
|  |  | Doctor Notes |  |  |  |  |  |  |

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| 1. Purpose of Release (coordination of care; information; continuity of care, etc.):
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Time limitation of Release: This consent is subject to revocation at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization.

This authorization expires one year from date of signature or the following date \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_ or in the event of Termination of Services (not to exceed one year).

Prohibition on redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and/or KY State Law. The Federal rules and/or KY state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and/or KY state law. A 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 client.

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Date Signature of Client/Resident/Patient
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Witness Signature of Client’s/Resident’s/Patient’s Agent or Representative

This form must contain original signatures. Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_

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| **COMPLETE BELOW ONLY IF THE CONSUMER WISHES TO REVOKE ABOVE AUTHORIZATION** |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ wish to revoke this authorization.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Signature of Consumer, Guardian, or Authorized Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date NewSong Counseling Center Witness |

 ADDENDUM A

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| 2. Communicating Person(s) or Agency(s) (Continued): Unless you are providing treatment to the client, you must specify name of an individual NOT a law firm, court, office, etc. |