AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME _____ DATE OF BIRTH_____

SOCIAL SECURITY # _____ DATES OF PROFESSIONAL SERVICES _____

1. I HEREBY REQUEST AND/OR AUTHORIZE _____
   TO DISCLOSE THE HEALTH INFORMATION, AS DESCRIBED BELOW, OF THE ABOVE-NAMED PATIENT TO:

2. INFORMATION TO BE RELEASED TO: **CASA SAN PIO CLINICS OF APPALACHIA**

   □ 638 EAST COLLEGE AVENUE, SUITE B STANTON, KENTUCKY 40380 PHONE: (606) 318-3500 FAX: (606) 318-3503

   OR TO THE FOLLOWING PERSON/ORGANIZATION: _____
   _____

3. INFORMATION TO BE RELEASED – CHECK YES OR NO AND INITIAL (MAY INCLUDE SUBSTANCE USE DISORDER RECORDS, IF APPLICABLE)

YES	NO	INFORMATION AUTHORIZED TO RELEASE	INITIALS
		MAJOR EVALUATIONS	
		TREATMENT PLANS	
		APPOINTMENT HISTORY	
		OFFICE NOTES	
		HISTORY & PHYSICAL	
		CONSULTATION NOTES	
		ADDICTION TREATMENT	
		URINE DRUG SCREENS	
		MEDICATIONS	

YES	NO	INFORMATION AUTHORIZED TO RELEASE	INITIALS
		ORDER & PROGRESS NOTES	
		DISCHARGE SUMMARIES	
		LABORATORY RESULTS	
		RADIOLOGY RESULTS	
		PATHOLOGY REPORTS	
		EMERGENCY ROOM RECORD	
		OPERATIVE REPORTS	
		NURSE NOTES	
		OTHER:	

4. PURPOSE OF RELEASE: □ Personal Interest □ Legal Claim Processing □ Social Security or Disability Claim
   □ Continuity of Care □ Insurance Claim Processing □ Other _____

5. TIME LIMITATION OF RELEASE: THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ THE FOLLOWING STATEMENTS:
   a. I understand that this authorization will expire □ one (1) year from date of signature □ on the following date _____ / _____ / _____ □ or upon disclosure of the records to the above-named Person/Organization.
   b. I understand that I may revoke this authorization at any time, providing the information has not already been disclosed. I also understand the Notice of Privacy Practices explains how I may revoke my authorization.
   c. I understand that any disclosure of this health information is voluntary, and I may refuse to sign this authorization and that I do not need to sign this form in order to ensure treatment.
   d. I understand that any disclosure of information carries with it the potential for the unauthorized redisclosure by the recipient and no longer protected by federal confidentiality rules.

Prohibition on redisclosure: I understand that this information has been disclosed from records protected by Federal confidentiality rules **(42 CFR Part 2 and 45 CFR Parts 160 and 164**) 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 patients. The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or records from other healthcare providers. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. **INITIALS _____**

6. I UNDERSTAND THERE MAY BE A CHARGE FOR THIS REQUEST AND I WILL BE NOTIFIED OF THE COST BEFORE ANY CHARGES ARE INCURRED.

7. RECORDS OF ROUTINELY MAILED. PERSONAL ID IS REQUIRED WHEN RECORDS ARE PICKED UP
   1 PHOTO ID OR 2 OTHER FORMS OF ID: □ SOCIAL SECURITY CARD □ DRIVER'S LICENSE □ SCHOOL/WORK ID □ OTHER _____

Date: _____ Patient Signature_____

Witness: _____ ***If signed by Representative:*** Printed Name: _____
Signature of Legal Representative: _____
Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____

REVISED 10/2019

The authorization must be signed by the patient if 18 years of age or over, or by a minor (under 18) if emancipated or otherwise eligible pursuant to KRS 214.185, or by the parent of legal guardian for any other minor or by patient's representative (i.e. Power of attorney); or if the patient is deceased, by the executor or administrator. An order or letter of approval from the court is needed as proof for executor or administrator and a written document is needed as proof of power-of-attorney. MR-15 Effective 04/14/2003