

Authorization for Use and Disclosure of Protected Health Information

Client Last Name _____ Client First Name _____ MI _____ Date of Birth _____

I authorize the exchange of information with the following person/agency: _____

Street Address _____ City _____ County _____ State _____ Zip _____

Phone Number _____ Email Address _____

Fax Number _____

COMMUNICATION

I authorize the following methods of communication for the purpose(s) marked below. I understand this includes discussion regarding substance use disorder treatment if applicable.

Mail (Letter)
 Electronic (Email)
 Verbal (Face to face or Telephone)
 Televideo (provider may participate through a platform offered by an outside entity, such as a school, which may not comply with all HIPAA guidelines)

PURPOSE OR NEED FOR THE DISCLOSURE - will include evaluation/care coordination in addition to the following:

Legal Proceedings
 School Placement
 Authorization / Billing of Treatment Services
 Other: coordination

RESTRICTIONS – the information identified will be released unless there are specific restrictions listed here:

TERM - I understand that this authorization will expire (Check one):

1 Year from Date Signed
 On the following date (not to exceed 1 year from date of signature): _____
 Upon the following specific event: _____

I understand that it is my responsibility to inform the FSGC Medical Records Clerk when the noted event has occurred. If the event has not occurred by one year from date of signature, this authorization will be automatically expired.

**I authorize Family Service & Guidance Center, Inc. to release or obtain the following written documents:
(Please only fill out this box if you want RECORDS to be released or obtained)**

	Release	Obtain		Release	Obtain	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical Information	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Admission Evaluation Report(s)	<input type="checkbox"/>	<input type="checkbox"/>	Progress Notes (please mark all needed)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Diagnosis Only Report	<input type="checkbox"/>	<input type="checkbox"/>	(<input type="checkbox"/> Therapy <input type="checkbox"/> CBS <input type="checkbox"/> Waiver <input type="checkbox"/> Crisis <input type="checkbox"/> SUD <input type="checkbox"/> Psychiatry)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Treatment Plan Report(s)	Date Range: _____		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical Psychiatric Consultation Report(s)	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clinical Psychological Evaluation Report(s)	N/A	<input type="checkbox"/>	IEP
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discharge Summary Report(s)	N/A	<input type="checkbox"/>	Grades
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization Screening Report(s)	N/A	<input type="checkbox"/>	Attendance
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	90 Day Review Reports			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Learning Disorder Report(s)	<input type="checkbox"/>	N/A	Client's Treatment Team Contact Information to School
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Substance Use Disorder Evaluation(s)			

READ CAREFULLY:

- I understand that under state and federal confidentiality provisions only the information specified can be released to the specified person or agency. (CFR – 42, part 2, KAR 30-60-47(b) (5), AAPS guidelines, Chapter 7).
- I understand that FSGC cannot ensure that the recipient will maintain confidentiality of this authorized release of information.
- I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of the authorization.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I understand that certain persons or organizations may not re-disclose substance abuse treatment information. (42 CFR, part 2) and that if my treating providers disclose my substance use disorder treatment records pursuant to this consent, the recipient will be provided a notice of nondisclosure.
- I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing written notice of revocation to FSGC.
- I understand that Protected Health Information provided on portable electronic media will not be encrypted and may be at risk for inadvertent disclosure if lost or stolen. By requesting the use of portable electronic media, I accept this risk.
- I understand that fees may be charged for preparing and sending copies of records.
- I understand that if I wish to restrict the release of documents or communication I should request the Request to Restrict Uses and Disclosures of Protected Health Information Form.
- I acknowledge that I have had the opportunity to ask and receive answers to all questions and have been offered/provided a copy of this release.

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Client Signature (age 14 or older)	Client Printed Name	Date
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Legal Guardian Signature	Legal Guardian Printed Name	Date

Prohibition on Rediscovery: 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 patient 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 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.