AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ (DOB: __/___/_____, SSN: XXX-XX-_____), authorize Addiction Recovery Care, LLC/Odyssey Inc. to release information contained in my medical record and/or financial statement to:

Name of agency and/or person: _____

Address: _____

Telephone: _____ Fax: _____ Email: _____

And/or its representative or entity for the purpose of:

_____

_____

_____

(Under the Mental Health Code, release of mental health information must be germane to the purpose and need for disclosure)

I understand that my records are protected under Federal Confidentiality regulations (42 CFR PART 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C Section 1320d, et. Seq and cannot be disclosed without my written consent unless otherwise provided for in the regulations. **I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions.** I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Addiction Recovery Care Privacy Liaison at 606-826-0144. I understand that a revocation is not effective to the extent that my treatment professional has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Name_____ DOB_____ SSN XXX-XX-_____

Information to be released: (Please check acceptable items)

☐ Bio-psychosocial Assessment ☐ Treatment History/Dates

☐ Treatment Plans & Reviews ☐ Laboratory Reports (specify each) ☐ Diagnosis ☐ Discharge Summary

☐ Targeted Case Management ☐ Peer Support

☐ Records of Alcohol and/or substance abuse treatment

☐ Letters for _____

☐ Other (Please specify): _____

You must specifically authorize the release of alcohol and/or substance abuse treatment records. A general release for "all medical records" is not sufficient.

Methods of Disclosure (check all that apply):

☐ Fax ☐ Verbal ☐ Written ☐ Photocopied

Pursuant to KRS 422.317, upon a patient's written request, a hospital licensed under KRS Chapter 216B or a health care provider shall provide, without charge to the patient, a copy of the patient's medical record. A copying fee, not to exceed one dollar ($1) per page, may be charged by the health care provider for furnishing a second copy of the patient's medical record upon request either by the patient or the patient's attorney or the patient's authorized representative.

____ Check here if you would like this to be your one and only free copy of your medical record

I understand that I may revoke this authorization at any time upon written notice to Addiction Recovery Care LLC/Odyssey, Inc. I acknowledge that such revocation will not be effective to the extent that Addiction Recovery Care LLC/Odyssey, Inc. has already acted in reliance upon this authorization. This authorization will terminate upon release of requested information.

Client Signature: _____ Date: _____

Witness Signature:_____Date:_____

OFFICE USE ONLY

Date Information Released: _____

Information Released To: _____

Method of Release: _____