Opportunity.
Hope.
Destiny.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, 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 condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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): _____

Methods of Disclosure (check all that apply):

☐ Fax ☐ Verbal ☐ Written ☐ Photocopied ☐ Electronic

Check here if you are requesting your one free copy of your medical record: ☐

KRS 422.317 requires that, 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 ($1.00) 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.

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: _____

NOTE: A COPY OF A PICTURE ID MUST BE ATTACHED TO THIS AUTHORIZATION FORM.

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR, Part 2) 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 such regulations. 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.