AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Instructions: Please complete all sections of release, if information is missing, the request will be sent back for completion.

I, _____,

DOB: ____/____/_____ SSN (only last 4 digits needed): XXX-XX- _____

☐ Addiction Recovery Care, LLC/Odyssey Inc.
☐ Bellefonte Hospital & Recovery Center Psychiatric Unit

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):

☐ Continuity of Care

☐ Legal Proceedings

☐ Personal Use

☐ Other:_____

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-_____

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

Information to be released: (Please check acceptable items)

- ☐ Bio-psychosocial Assessment
- ☐ Comprehensive Assessment
- ☐ Diagnosis
- ☐ Discharge Summary
- ☐ Laboratory Reports (specify each): _____
- ☐ Letters Regarding: _____
- ☐ Medications
- ☐ Other (Please specify): _____
- ☐ Peer Support
- ☐ Physical Examination
- ☐ Targeted Case Management
- ☐ Treatment History/Dates
- ☐ Treatment Plans & Reviews

Methods of Disclosure (check all that apply):

☐ Fax ☐ Email

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., Bellefonte Hospital & Recovery Center Psychiatric Unit 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:_____