Restoration Christian Counseling

100 W. Oak St., Nicholasville, KY 40356

Authorization for Release of Information

- I understand that my permission is required to release health care information related to testing, diagnosis, and/or treatment of psychiatric disorders/mental health, drug or alcohol use, HIV/AIDS, or sexually transmitted diseases
- If there is information related to any of the above mentioned in my medical records, you are specifically authorized to release it.
- I am hereby giving my voluntary consent and have been informed of the type of information that has been requested.
- Any and all of my information may be released by written or verbal form. The benefits and/or disadvantages of releasing such information has been explained to me.
- I do acknowledge and understand that conditions of services does not depend on my decision concerning the release of information.

LIMITATION OF RELEASE:

This authorization expires sixty (60) days from the date of the signature. I understand I may revoke this authorization at any time by signing the bottom of this form. Restoration Christian Counseling however cannot be responsible for release of information prior to notification or when required by law.

Name of Client	Date
Date of Birth	Social Security Number

Disclosed to ____ Received from ____ Name of Person/Agency _____

Address _____

Medication/Laboratory ___ Evaluation/Assessment ___ Progress Notes ___

Discharge Summary ___ Treatment/Services ___ History/Physical Exam ___

Other _____

The purpose of this disclosure is for: Use in Treatment ____

Other _____

PROHIBITION OF DISCLOSURE: According to 45 CFR 164,508 c2CIII, health information may be redisclosed by the recipient. However, pursuant to KRS 304.17A-555, PATIENTS RIGHTS OF PRIVACY REGARDING MENTAL HEALTH OF CHEMICAL DEPENDENCY AUTHORIZED DISCLOSURE mental health/chemical dependency information may not be used and/or shared by the recipient of said information unless specific, written consent for disclosure is authorized by the person to whom it pertains. Additionally, FEDERAL REGULATION 42 CFR, PART 2 prohibits further disclosure of this information without specific written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical records 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 patient.

I understand that the information being requested for all minors age 17 years and younger may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.

_____ _____

Signature of Client/Parent or Guardian Date

_____ _____

Signature of Witness Date

**********I WISH TO REVOKE THE ABOVE AUTHORIZATION**********

_____ _____

Signature of Client/Parent or Guardian Date