



Center for
Counseling
Health
and Wellness

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

1. Identity

Client Name: _____ Social Security Number: _____
Address: _____ Date of Birth: _____
Phone Number: _____

2. Sender and Receiver

I authorize disclosure of medical information (as indicated) *from and to* THE CENTER FOR COUNSELING, HEALTH, AND WELLNESS, PLLC, Post Office Box 24611, 1600 Harrodsburg Road, Lexington, KY 40524-4611. I authorize disclosure of medical information (as indicated) *from and to*:
Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, KY 40222, 502-429-7150 (phone), 502-429-7158 (fax)

Person/Agency, Address, and Telephone Number

3. Timeframe

I would like records from the following dates: _____ through _____.

4. What to disclose

Please check the records you would like disclosed:

Records related to (specify): _____ Assessment Diagnoses
 Discharge Summary Lab Report(s) Psychological Test Report Other (specify): _____

5. Type of Disclosure

Deliver by Mail Onsite Review Permission to Discuss Care Other (specify): _____

6. Disclosure of Special Protected Records

- a. The diagnosis or treatment of AIDS, including the results of HIV tests
 Yes No/NA
- b. The diagnosis or treatment of drug and/or alcohol abuse or dependence
 Yes No/NA
- c. Treatment and/or consultation for mental health or psychiatric disorders
 Yes No/NA

7. Purpose of Use/Disclosure Please indicate/describe each authorized purpose of the use or disclosure:

Request of individual Provide Continuum of Care Other (specify): _____

8. Expiration Date This authorization will expire in 90 days or _____, whichever occurs last.

- I understand that I may revoke this Authorization at any time, unless the Authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing; and that the revocation shall be effective *except* to the extent that the Facility has already used or disclosed information in reliance on the Authorization.
- I further understand that treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however, Facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this Authorization, and Facility may condition the provision of research-related treatment on my signing this Authorization.
- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the Facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

Date Signature of Client

If client is unable to sign, secure consent of Legal Representative and indicate reason below: _____
 Minor Incompetent Deceased Signature of Legal Representative and Relationship to Client

Revised 12/2010 Signature of Witness