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 Pharmacy, State Office Building Annex, Suite 300, 125 Holmes Street, Frankfort, KY 40601, 502-564-7910 (phone), 502-696-3806 (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

_____
Signature of Witness

Revised 12/2010