MOUNTAIN COMPREHENSIVE CARE CENTER, INC.

104 South Front Avenue, Prestonsburg, Kentucky 41653

AUTHORIZATION TO RELEASE/REQUEST CLIENT PROTECTED HEALTH INFORMATION

Name ______________________ S.S. No. ______________________

Birth Date ______________________ Dates of Treatment/Services ______________________

The undersigned hereby authorizes ______________________ (Name of Entity Sharing Information) ______________________ (Address) to release Protected Health Information from the Medical Record of the individual named above

TO: ______________________ (Name)

______________________ (Address)

TYPE OF INFORMATION TO BE RELEASED:

___ Admission Summary ___ Progress Notes ___ Treatment Plans ___ Lab Tests

___ Psychological Eval. ___ Psychiatric Eval. ___ Discharge Summary ___ Current Medical Status

___ Drug Abuse, Alcohol Abuse Treatment Notes

___ Treatment information which may include Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndromes (AIDS) or Tests for HIV

___ Other (Specify) ______________________

PURPOSE for Release of Information ______________________

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REFUSAL TO SIGN: I understand that I may refuse to sign this authorization and that MCCC will not allow my refusal to interfere with the receipt or payment of behavioral health services.

REVOCATION: I understand that I may revoke this authorization by notifying MCCC Medical Records Staff on site in writing. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by MCCC in reliance on it before I revoked it.

TIME LIMITATION OF RELEASE: Unless previously revoked, this authorization shall expire on: ____________, 20___ (not to exceed one year); or 60 days from the date of the authorization if a date is not specified.

PROHIBITION ON REDISCLOSURE: I understand that pursuant to KRS 304.17A-555 Patient's Right of Privacy Regarding Mental health or Chemical Dependency - Authorized Disclosure, my Protected Health Information, used and/or shared under this authorization may not be shared again by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the redisclosure.

ADDITIONAL RESTRICTIONS: This information disclosed is protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. 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 patient.

I am giving this consent voluntarily. I have read and understand this authorization. I understand all information designated above will be released.

______________________ ______________________

SIGNATURE of Client or Personal Representative Date

______________________ ______________________

WITNESS Date

If not signed by client, specify basis for authority to sign: ___Parent ___Guardian ___Other ______________________

Revocation of Release: Signature ______________________ Date ____________

— — — — — — — — — — **FOR OFFICE USE ONLY** — — — — — — — — — —

Date information released: ____________, 20___ Free Copy: ☐Yes ☐No Charge $ ____________

Signature of staff releasing information ______________________

MCC-MR Form -016 (01-14-04)

Authorization For Release/Request Client Protected Health Information

ITEM	ACTION
Name	Client name: Last, First, MI
S.S. No.	Client's Social Security Number
Birth Date	Client's date of birth
Dates of Treatment/Services	Dates of Treatment/Service to be released/requested
Authorizes	Name and address of entity releasing protected health information
To	Name and address of entity receiving protected health information
Type of Information	Check type of information to be released/requested
Purpose for Release	Enter reason information released/requested
Refusal to Sign	Explain client's right to refuse to sign authorization
Revocation	Explain client's right to revoke authorization
Time Limitation	Expires in 60 days unless otherwise noted
Prohibition on Redisclosure	Explain information can't be redisclosed without client consent
Additional Restrictions	Explain alcohol and substance abuse treatment information can't be redisclosed, without client consent
Signature	Client or Personal Representative's signature
Date	Enter date signed by client
Witness	Enter witness's name
Date	Enter date signed by witness
Authority	Mark whether parent, guardian or other, if not signed by client
OFFICE USE ONLY	
Date Information Released	Enter date information was released or mailed
Free Copy	Check if client's free copy
Charge	Enter the amount charged, $1.00 per side, if not first free copy
Signature of Staff Releasing	Enter name of staff member releasing information