ROI UPDATED:

Client Name: _____ **Client SSN/ID:** _____

Authorization for Release of Information

Date: _____ **Date of Birth:** _____ **SSN:** _____

Disclosing and Receiving Parties

Cumberland River Location: _____

Outside Location: _____

Release of Information To/From:

- ○ Release of Information from CRBH
- ○ Release of Information to CRBH
- ○ Release of Info From and To CRBH

Indicate Specific Information to be EXCLUDED from this authorization if any (Mark X for any exclusions)

- ○ Drug/Alcohol Records
- ○ Mental Health Records
- ○ HIV/AIDS Records
- ○ Infectious Disease Records

Treatment Dates to Release

- ○ Any and All Records
- ○ Date Range **From:** _____ **To:** _____

Explain (This area is for "Why are you releasing information")

I hereby authorize the release of the following specific information. (Mark "Yes" or "No" to authorize or deny) disclosure of each medical record form.

Intake Assessment
○ Yes ○ No

Psychiatric Evaluation, Psychological Evaluation
○ Yes ○ No

Assessments (e.g. AIMS, CANS, ANSA, NOMS)
○ Yes ○ No

Medication/Injection Log
○ Yes ○ No

Discharge Summary/Continuity of Care Document
○ Yes ○ No

Progress Notes
○ Yes ○ No

Laboratory Tests
○ Yes ○ No

Activity History
○ Yes ○ No

Care Plan
○ Yes ○ No

Billing Information
○ Yes ○ No

Client Name: _____ **Client SSN/ID:** _____

Other

Yes **No**

Explain Other:

I understand that this information will be used for the following specific purposes: (Mark "X" under the "Yes" or "No" to indicate the purpose of the disclosure).

To develop a diagnosis, treatment, and rehabilitation plan

Yes **No**

To coordinate medical, psychological, and social rehabilitative process

Yes **No**

To determine eligibility or process insurance claims for services provided

Yes **No**

Legal proceedings

Yes **No**

Client's request

Yes **No**

Other

Yes **No**

Specify Other:

I understand that my records are protected under state and federal confidentiality statures and/or regulations, and that the information used or disclosed may be subject to re-disclosure by the person(s) receiving it and no longer protected by the federal privacy regulations.

I further understand that these records will not be disclosed without my written authorization unless otherwise allowed by state or federal statutes, rule, or regulation.

I authorize the use of a photocopied, faxed, or a scanned presentation of this form as a valid original for the release or disclosure of the information described above.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Cumberland River.

Client Name: _____ **Client SSN/ID:** _____

I understand that I may revoke this authorization at any time, except to the extent that Cumberland has already acted in reliance on the authorization. A revocation should be in writing (unless otherwise permitted by law) and delivered to Cumberland River Comprehensive Care Center, CRBH – P.O. Box 568 – Corbin, Ky 40701.

This authorization automatically expires 1 year after the date that I sign it. This authorization for release of information is given freely, voluntarily, and without coercion.

_____

Client Signature **Date**

_____

Witness Signature **Date**

_____

Parent/Guardian Signature **Date**

ROI REVOKED:

ROI Revoked **Date Revoked** _____

Yes **No**

Information Regarding Revocation

_____

Client Signature **Witness Signature**