

**Authorization to Disclose Information to Education & Labor Cabinet/Medical Review Team**

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
Facility Name: \_\_\_\_\_ Dates of Service (If known): \_\_\_\_\_

**PART I: Information Regarding Medical Information to be Released**

I, the above-named patient, voluntarily authorize and request disclosure (including electronic interchange) of all my medical records; and/or educational or other information relevant to my ability to perform tasks. This includes specific permission to release to the Cabinet for Health and Family Services/Education & Labor Cabinet/Medical Review Team all records or other information regarding my treatment, hospitalization and/or outpatient care for my impairment(s) **including, but not limited to:**

- Psychological or psychiatric impairment(s) (Including evaluations, therapy and/or progress notes),
- Drug Abuse or alcoholism,
- Sickle Cell Anemia,
- Human Immunodeficiency Virus (HIV) infection,
- Acquired Immunodeficiency Syndrome (AIDS),
- Sexually transmitted diseases, or

- Tests for any of the previously listed diseases,
- Therapy and psychotherapy notes of the previously listed diseases,
- Information about how my impairment(s) affects my ability to complete tasks and activities of daily living or affects my ability to work.

This information may be obtained from the following sources:

- All medical/mental health sources (hospitals, clinics, doctors, psychologists, labs, mental health facilities, etc.)
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social Workers/ Rehabilitation Counselors
- Consulting examiners

**PART II: Rights and Responsibilities Pertaining to Release of Medical Information**

I understand that this information will be released to the Cabinet for Health and Family Services/Education & Labor Cabinet/Medical Review Team for the purpose of processing my application for benefits.

I understand that although the information obtained with this form is almost never used for any purpose other than previously stated, the information **may be redisclosed** by CHFS/ELC/MRT without my consent if authorized by State Law or Federal Laws such as the Privacy Act or 42 CFR Part 2.

I understand that I may cross out and initial any of the information above if I do not want that information used to make a decision on my case.

I understand that signing this form is voluntary, but failing to sign it, or revoking it before the necessary information is obtained, could prevent an accurate or timely decision on my application and could result in denial or loss of benefits.

I understand that my consent for the release of AIDS/HIV information or information containing alcohol or drug treatment is based upon the fact that this information will not be shared with anyone else.

I understand that I am entitled to a copy of this form if I ask for it; I may also request a copy of the information obtained with it.

I understand that once medical information is disclosed to the Cabinet for Health and Family Services/Education & Labor Cabinet/Medical Review Team, it is no longer protected by the health information privacy provisions of 45 CFR Parts 160 and 164, mandated by the Health Insurance Portability and Accountability Act (HIPAA).

I understand this authorization is not only for past information, but also any relevant information created after the date of this authorization.

I understand that I may revoke this consent at any time in writing except to the extent that action has already been taken based on my consent.

I understand this authorization will expire within 12 months of the date it is signed, or when a final decision is made on my case.

**PART III: Patient / Witness Signature**

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

***MUST BE SIGNED BY THE PATIENT!*** If not signed by the patient, specify basis for authority to sign:

**Power of Attorney**                       **Legal Guardian**                       **Parent of Minor Child**

**WITNESS:** I know the person signing this form or am satisfied of this person's identity:

**WITNESS SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_