newvista

Health Information Management
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Authorization for Release of Information

Type of Release: ☐ Permission to Discuss Care Only ☐ Treatment Records Only ☐ Permission to Discuss Care and Treatment Records Needed

Client Name _____ **Date of Birth** _____ **SSN** _____

Dates of Health Information Being Requested: _____ Through _____

Please select the following information you would like to obtain:

☐ Evaluation/Assessment ☐ Progress Notes ☐ Treatment Plan(s) ☐ Lab Results ☐ E/M Notes
☐ Safety Plan(s) ☐ History/Physical Exam ☐ Medications ☐ Discharge Summary ☐ **Other (explain below)**

The release of this information is for the purpose of: ☐ Use in future treatment ☐ Other (explain): _____

This release will expire sixty (60) days from the signature date below or on: _____.

☐ Receive Information From **or** ☐ Send Information To: _____ _____
Name of Party Receiving Information **Role/Relationship to Client**

Street Address _____ **City** _____ **State Zip** _____

Phone _____ **E-mail** _____ **Fax** _____

- I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of psychiatric disorders/mental health, drug and/or alcohol use, HIV/AIDS or sexually transmitted diseases. If there is information pertaining to psychiatric disorders/mental health, drug and/or alcohol use, HIV/AIDS or sexually transmitted diseases in my medical record, you are specifically authorized to release it. I am giving this consent voluntarily and have been informed of the specific type of information that has been requested. Information may be released in written or verbal format. Benefits and disadvantages of releasing information have been explained to me. I understand that provision of service does not depend on my decision concerning the release of information.
- **PROHIBITION ON REDISCLOSURE:** According to 45 CFR 164.508 c2Ciii health information may be re-disclosed by the recipient. However, pursuant to **KRS 304.17A-555, *Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure*** mental health/chemical dependency info may not be used and/or shared by the recipient of said information unless specific, written consent for re-disclosure is authorized by the person to whom it pertains. Additionally, **Federal Regulations 42 CFR, Part 2** prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. If a general designation is identified for disclosure on this release, you have the right to obtain, upon request, a list of entities to which your information has been disclosed. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. You may report violations to the United States Attorney at 260 W. Vine St., Ste. 300, Lexington, KY 40507-1612 and/or to the Substance Abuse and Mental Health Services Administration office at 5600 Fishers Ln., Rockville, MD 20857.
- I understand I may revoke this authorization at any time by signing the bottom of this form. New Vista, however, cannot be responsible for any release(s) of information prior to notification or when required by law.

Client's Signature _____ Date _____

Parent/Guardian Signature is required for all minors age 17 years or younger. Please read the following information before signing.
I understand that the information being requested for the above named minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.

Signature of Client's Parent/Legal Guardian _____ Relationship to Client _____ Date _____

Signature of Witness ***(required on all releases)*** _____ Date _____

******* By signing below this line, I wish to revoke the above authorization *******

Signature _____ Date _____