DCBS-1A
(R. 6/18)

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services

INFORMED CONSENT AND RELEASE OF INFORMATION AND RECORDS SUPPLEMENT

Name_____ **SSN**_____

I authorize the Department for Community Based Services (DCBS) and the following agencies and individuals:

Name of Agency or Individual	Name of Agency or Individual

To disclose to and communicate to one another the following information and records for:

Name _____ SSN _____:

CHECK EACH CATEGORY THAT APPLIES

- ☐ My name and other personal identifying information
- ☐ Information about my status as a patient in alcohol or drug treatment
- ☐ Information about my status as an HIV or AIDS patient
- ☐ Initial evaluation
- ☐ Date of admission
- ☐ Assessment results and history
- ☐ Summary of treatment plan, progress and compliance
- ☐ Attendance
- ☐ Date of discharge and discharge status
- ☐ Discharge plan
- ☐ Employment related information
- ☐ Education and training related information
- ☐ Other (specify)_____
  _____

I understand that the purpose of these disclosures is to enable the DCBS staff, or staff of another agency authorized to act on the DCBS' behalf, and the designated agencies and individuals to disclose and receive information and records to and from one another as may be necessary for the purpose of the determination of eligibility for assistance programs and the development and delivery of services.

NOTICE OF PROHIBITION ON REDISCLOSURE:
Any consent that I have provided for the disclosure of my AIDS/HIV information, or information concerning alcohol or drug abuse treatment, is based on a prohibition of redisclosure. The designated individual or agency that receives my information regarding HIV or AIDS or alcohol or drug abuse treatment information shall not make any further disclosure of such information without my specific written consent, or as otherwise permitted by state law or 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

I understand that:

- This authorization will be in effect for a period of _____ (not to exceed 12 months) from the signature date.
- I may revoke this consent at any time in writing unless action has already been taken based on my consent.
- DCBS will not condition treatment, payment, enrollment or eligibility for benefits on receipt of this form. 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 response and could result in denial or loss of benefits.
- Information disclosed to DCBS may no longer be protected by the health information privacy provisions of 45 CFR Parts 160 and 164 pursuant to the Health Insurance Portability and Accountability Act (HIPAA).
- Information may be redisclosed by DCBS without my consent if authorized by State Law or Federal Laws such as the Privacy Act or 42 CFR Part 2 or to comply with laws regarding mandatory reporting of suspected abuse, neglect or exploitation, or assessment that there is a danger of serious harm to self or others.
- I have received a copy of this form. I may also request a copy of the information retained with it.

Signature_____Date_____

[ ] Client [ ] Parent [ ] Legal Guardian
[ ] Other person authorized to sign in lieu of client (specify)_____

Witness Signature_____ Date_____
[ ] DCBS worker (specify program area)_____
[ ] Other agency staff (specify)_____