



Release of Information

Patient Name _____ DOB _____ Client ID _____

I hereby authorize NKRC to (select one):

- Disclose Information
Receive Information
Exchange Information

Authorized individual/organization (Name & Title) _____

Address of Authorized individual/organization _____

Phone Number of Authorized individual/organization _____ Fax Number _____

- Purpose of Disclosure: Health Insurance Billing/Authorization, Continuity of Care, Treatment Planning/Case Management, Continued Employment/Fitness for Duty, FMLA, Short Term Disability, Legal, OTHER - Specify

Disclosure of information pertains to dates of treatment ranging: FROM (Date): _____ Through (Date): _____

Act 148 Confidentiality of HIV-Related Information Act prohibits the disclosure of HI-related information without permission of the subject except in certain limited instances.

I consent to the disclosure of (please check all that apply):

- Progress Notes, Diagnostic Assessment Information, Lab Results, Urine Testing, HIV/AIDS Testing or Status, Pregnancy Testing, Prenatal Care, Diagnoses, Discharge/Summary Planning, Information on Mental Illness and/or Treatment, Medications, Insurance Cards, Immunization Records, Academic/School Records, Demographics, OTHER - Specify

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent verbally or in writing at any time except to the extent that information has been released prior to the date of revocation by contacting Medical Records. In any event, this consent shall expire one year from the date of signature.

Unless I have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information permitted by this authorization in any manner that we deem to be appropriate and permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C. F. R. Part 2.

Patient Signature

Date

Parent/Responsible Party Signature (If required)

Date

Witness Signature

Date

Copy Accepted

Copy Refused