AUTHORIZATION FOR RELEASE OF INFORMATION

1. The undersigned hereby request and/or authorize:

to release the medical record of:

Name:	SS# - -
Birth Date: / /	Dates of Professional Service:

2. Information to be released to: Unless you are providing treatment to the client, you must specify name of an individual NOT a law firm, court, office, etc. If additional space is needed, add individual names on Addendum A. Check the "Yes" box if additional names are included on Addendum A or "No" if there are no additional names. ☐ Yes ☐ No

Address:	Phone:
City: State: Zip:	

3. Information to be released – check yes or no AND initial (may include substance use disorder records, if applicable).

YES	NO	INFORMATION AUTHORIZED TO RELEASE	INITIALS	YES	NO	INFORMATION AUTHORIZED TO RELEASE	INITIALS
		Major Evaluations				Medications	
		Treatment Plans				Progress Notes	
		Appointment History				Other:	
		Doctor Notes					

4. Purpose of release:

Time limitation of Release: This consent is subject to revocation at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization.

This authorization expires one year from date of signature or the following date _____/____/_____ or Event_________________________________ (not to exceed one year).

Prohibition on redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and 45 CFR Parts 160 and 164) and/or KY state law. The Federal rules and/or KY state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and/or KY state law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

______________________________ Date

______________________________ Signature of Client/Resident/Patient

______________________________ Witness

______________________________ Signature of Client's/Resident's/Patient's Agent or Representative

This form must contain original signatures.

Relationship: ______________________________

Address: ______________________________

City: ______________ State: ___________ Zip: ___________

COMPLETE BELOW ONLY IF THE CONSUMER WISHES TO REVOKE ABOVE AUTHORIZATION

I, ____ wish to revoke this authorization.

______________________________ Date

______________________________ Signature of Consumer, Guardian, or Authorized Representative

______________________________ Date

______________________________ Pathways, Inc. Witness

ADDENDUM A

2. Information to be released to (Continued): Unless you are providing treatment to the client, you must specify name of an individual NOT a law firm, court, office, etc.