AUTHORIZATION TO DISCLOSE PATIENT INFORMATION

I, _____ _____ _____
Name of Patient *(Please print)* Date of Birth/SSN/Medical Record # Date(s) of Treatment

Hereby authorize: The Brook Hospital KMI
8521 LaGrange Road
Louisville, Kentucky 40242
502-426-6380

and/or

The Brook Hospital Dupont
1405 Browns Lane
Louisville, Kentucky 40207
502-896-0495

To obtain from _____ and/or disclose to _____ protected health information as indicated below to:

Name: _____ Agency: _____

Address: _____
Street City State Zip Code

Phone: _____ Fax: _____

PROTECTED MENTAL HEALTH/SUBSTANCE ABUSE INFORMATION TO BE USED AND/OR DISCLOSED *(must be specific)*

❑ Discharge Summary ❑ Psychiatric Evaluation ❑ H & P ❑ Other (specify): _____

PURPOSE INFORMATION IS BEING USED/DISCLOSED *(must be specific)*

❑ Continuing Care ❑ Legal Issues ❑ Insurance ❑ Disability Claim ❑ Other (specify): _____

- I authorize the use and disclosure of protected health information, including but not limited to, medical, psychiatric, psychological, drug/alcohol and HIV/AIDS records as indicated above. I release **The Brook Hospital**, its employees, agents, directors, officers, and affiliates, from any liability that may be incurred by giving this information to the above-named person or agency.
- I understand that I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been used/disclosed in response to this authorization or information disclosed for the purpose of receiving reimbursement from a third-party payer.
- I understand that this authorization will **expire 90 days** from the signature below.
- I understand that The Brook Hospital will not determine treatment or payment based on my approval or denial of authorization.
- I understand that this information being disclosed is confidential and protected by federal law. The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations, including the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**). Federal regulations (**42 CFR, Part 2**) prohibit the receiver of this information from making any further disclosures of the same, except with the written authorization of the person to whom it pertains. A General Authorization for the release of medical/psychiatric information is not sufficient for this purpose.
- I further understand that once this information has been disclosed to the person/organization listed above, **The Brook Hospital** no longer may provide protection against further uses ad/or disclosures by said person/organization or any subsequent recipient.

I have read, or been informed, that all blanks were properly filled in prior to my signature. I understand that, by signing this form, I am confirming my authorization that The Brook Hospital may receive, use, and/or disclose to the persons and/or organizations named in this form.

_____ _____
Signature of Patient (includes minors 16 years and older) Date

_____ _____
Signature of Requestor (if other than Patient)* Witness

*Relationship to Patient: ❑ Parent ❑ Legal Guardian (i.e., Power of Attorney, custodial parent, etc.) ❑ Other: _____

_____ Proof of guardianship received or on chart **_____ I.D. Checked**

For Hospital Staff Only: **First Free Copy: ❑ Yes ❑ No**

Information disclosed: _____ Date: _____ Staff Signature: _____

Has Patient provided written revocation? ❑ Yes Date: _____ Staff Signature: _____