Authorization for Release of Protected Health Information

INSTRUCTIONS FOR COMPLETING THIS FORM

Complete all applicable sections.
Sign and date the form.

Please choose one:

Mail:

Stepworks
PO Box 6209
Elizabethtown, KY 42701-6209

Fax:

(859) 878-1024
ATTN: Medical Records

In person:

Take the completed form to the Stepworks facility at which you were a patient.

To pick up records when you submit this form, **please call the facility first** to arrange a time: (800) 545-9031
We will only release records in person to you or your legal representative, and a valid form of ID is required.
If this is not your first copy, a charge of $1/page will be required **prior** to releasing your records.

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2).
42 CFR Part 2 prohibits unauthorized disclosure of these records.

Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: ____ / ____ / _____

Social Security Number: _____-_____-_____ Phone Number: (_____) _____ - _____

Location: ☐ London ☐ Woodland ☐ Crowne Pointe ☐ Bowling Green ☐ Nicholasville ☐ Intensive Health ☐ Paducah
☐ Sober Living ☐ IOP/PHP

I authorize Stepworks Recovery Centers to:

☐ RELEASE Medical Records to: ☐ OBTAIN Medical Records from:

Name: _____

Street Address: _____ City: _____ Zip Code: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

I request that my records be ☐ Faxed ☐ Picked up in person ☐ Certified mailed to person/entity above

Initial _____ I request my medical records be sent via unencrypted email. I understand that email is not secure, and any email or email attachment could be intercepted or read by a third party. If you do not consent to this, your records cannot be sent via email.
Email address: _____

Purpose of Request

☐ continuity of care ☐ personal use ☐ vocational rehab
☐ legal circumstances ☐ referral ☐ placement/disposition
☐ insurance ☐ disability determination ☐ other: _____

Information Requested (check all that apply)

All information released may contain private health information related to substance abuse treatment.

☐ discharge summary ☐ intake/assessment ☐ lab results (except HIV/Hepatitis)
☐ HIV and/or hepatitis results ☐ treatment plan ☐ biopsychosocial evaluation
☐ progress notes ☐ medical tests/studies ☐ other: _____

If requesting a specific date or length of stay, please provide that here: ____ / ____ / _____

I understand I can revoke my consent at any time except when disclosure has already taken place, in which case consent will expire on ____ / ____ / _____ or 90 days from the date on which this form was signed. I understand my records may not be released to me at the same time as requested. I understand I am entitled to one free copy of my medical record. Any additional copies will be $1 per page.

This information has been disclosed for records protected by federal confidentiality rules (42 CFR Part 2). Federal rules prohibit anyone 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. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

Patient/Legal Representative Signature: _____ Date: ____ / ____ / _____
Witness Signature: _____ Date: ____ / ____ / _____

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