Authorization for Release of Protected Health Information

INSTRUCTIONS

Read and complete all sections on the next page.
Sign and date the form.

Send Stepworks the Completed Form by Choosing One Option Below:

Mail:
Stepworks Medical Records
PO Box 6209
Elizabethtown, KY 42701-6209

Fax:
(859) 878-1024

In Person:
Take the completed form to the closest Stepworks facility.

If you want to pick up your records…

Call the facility first to arrange a time: (800) 545-9031. We will only release records to you or your legal representative. Valid ID is required. If this is not your first copy of records, a chart of $1/page is required before the records will be released.

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.

stepworks

PO Box 6209, Elizabethtown, KY 42702-6209
Phone: (606) 227-1172 | **Fax**: (859) 878-1024

Authorization for Release of Protected Health Information

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

Social Security Number: _____ - _____ - _____ Phone Number: _____

I authorize Stepworks Recovery Centers to:

CHECK ONE: ☐ **RELEASE** Medical Records to: ☐ **OBTAIN** Medical Records from:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I request that my records be: ☐ faxed ☐ certified mailed to person/entity above ☐ picked up in person (ID required)

_____ Initials

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 initial, your records cannot be sent via email.) **Email address:** _____

Information to be Disclosed

I understand the information released may include information relating to substance abuse, mental health, sexually transmitted diseases, AIDS/HIV, and/or hepatitis.

I authorize the release or disclosure of the following records:

☐ **ALL MEDICAL RECORDS**

☐ **OR** the following **SPECIFIED** records (check all that apply):

- ☐ residential treatment episodes
- ☐ Intensive Health records
- ☐ discharge status (e.g., completion, AMA, etc.)
- ☐ attendance/participation in program
- ☐ biopsychosocial evaluation
- ☐ progress notes
- ☐ discharge summary
- ☐ medical data (assessments, vitals, detox notes, etc.)
- ☐ outpatient (PHP/IOP) treatment episodes
- ☐ sober living records
- ☐ treatment plan and updates
- ☐ appointments
- ☐ referral information
- ☐ lab results (including urine drug screens)
- ☐ medications
- ☐ other *(specify)* _____
- ☐ do **NOT** release any information related to AIDS/HIV, STDs, and/or hepatitis

Dates of Information to be Disclosed

☐ all dates of service ☐ the last year ☐ from ____ / ____ / _____ to ____ / ____ / _____

Purpose of Disclosure

☐ personal ☐ continuity of care ☐ disability determination

☐ legal circumstances ☐ referral ☐ other (specify): _____

I understand that I can revoke my consent at any time by speaking to a Stepworks staff member, except when disclosure has already taken place, in which case my consent will expire 60 days from the date this form was signed. You are entitled to one free copy of your medical records. Additional copies are $1 per page.

42 CFR Part 2 prohibits unauthorized use or disclosure of these records.

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

Witness Signature: _____ Date: ____ / ____ / _____