Insight Behavioral Health Associates
Authorization for Release of Information

Please fill out all sections of the form or we may not be able to fulfill your request.

Patient Name: ____ Social Security Number: _______-______-_________

Address: ____ Date of Birth: ________________________

City: ________________________ State: _____ Zip: _____________ Phone Number: (______) _______ - ___________

Send and/or allow Information to be exchanged **from:**	Send and/or allow Information to be exchanged **to or with:**
Insight Behavioral Health Associates 1000 E. Lexington Ave. Ste. 30 Danville, KY. 40422 Ph. (859) 209-2198 Fax: (859) 209-4439	(i.e.: Insurance Company, Pharmacy, PCP, Attorney, Family Member Therapist/counselor)

I would like Records or Information to be exchanged from (dates) ________________ **through or to** ___________________.

(This can be a very specific date or more general. Examples: July 15, 2007 or June 2006 - Feb 2007 – It may also be predated up to one year to allow for continued collaborative information exchange – permission will be reviewed annually, revoked upon discharge, and may be revoked by the patient at any time)

Please Check the Records and/or Information permitted to be exchanged:

*This may include verbal communications intended to clarify the pertinent information necessary for the collaboration and coordination of care and expands upon Insight Behavioral Health Associates' existing Privacy policy available at www.Insightbha.com.

- ☐ Outpatient notes, problem list(s), or summary of care document(s).
- ☐ Discharge Summary
- ☐ All Known Medical Records
- ☐ Medication Records
- ☐ Laboratory Report(s)
- ☐ Any prior ECG
- ☐ X-Ray / MRI Report(s)
- ☐ X-Ray / MRI Image(s)
- ☐ Counseling / Therapy Notes / Diagnostic Summaries
- ☐ Psychiatric Tests or Reports
- ☐ Other: ___________________________

Sharing of Special Protected Records: I authorize the sharing of information about:

The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS) Yes ____ No/n/a ____
The diagnosis or treatment of drug and/or alcohol abuse Yes ____ No/n/a ____
The treatment and/or consultation for mental health or psychiatric disorders Yes ____ No/n/a ____

Reason records and/or information will be exchanged (check all that apply):

- ☐ For Another Provider
- ☐ Social Security and Disability
- ☐ Legal
- ☐ Personal Use
- ☐ Collaboration and Coordination of Care
- ☐ Other: _________________________________

This Authorization will expire on(date) ___________________**.** If no date is included the Authorization will expire in 90 days.

- ❖ I understand that I may revoke this Authorization at any time, unless the Authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing to the Registration Office at the Facility/location where I originallysubmitted/filed this authorization; and that the revocation shall be effective except to the extent that the Facility has already used or disclosed information in reliance on the Authorization.
- ❖ I further understand that treatment payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however, Facility may condition the provision of health care that is solely for the purpose of creating protected healthinformation for disclosure to a third party on my signing this Authorization, and Facility may condition the provision of research-related treatment on my signing this Authorization.
- ❖ I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

____
Signature of Patient or Legal Representative.

_____/_____/_________
Date

____
Printed Name

____
Relationship to Patient if not signed by the Patient

____
Signature of Witness for Psychiatric records

If patient is unable to sign release, secure consent of Legal Representative and indicate reason below:

- ☐ Patient is a Minor
- ☐ POA /Guardianship
- ☐ Deceased
- ☐ Other: ____________

(Attach supporting Document(s))