LifeSkills, Inc.

Authorization to Use or Disclose Protected Health Information

THE UNDERSIGNED HEREBY AUTHORIZES THE USE OR DISCLOSURE OF INFORMATION FROM THE MEDICAL RECORD OF:

_____ _____

(NAME) (S.S. Number)

_____ _____

(Birth Date) Dates of Treatment/Service

☐**FROM:** LifeSkills, Inc. ☐**TO:** _____

380 Suwannee Trail _____

Bowling Green, KY 42102 _____

☐**TO:** LifeSkills, Inc. ☐**FROM:** _____

380 Suwannee Trail _____

Bowling Green, KY 42102 _____

TYPE OF INFORMATION TO BE USED OR DISCLOSED: **(client must initial each marked item)**

_____ Psychiatric Evaluation	_____ Dates of Treatment	_____ Progress Report
_____ Admission/Intake	_____ Discharge/Termination Summary	_____ Assessment
_____ Labs & Radiology results	_____ DCBS Involvement	_____ IEP
_____ Crisis Report	_____ Psychological Testing/Assessment	_____ Medication History
_____ Staff Notes	_____Vocational Evaluation	_____Treatment Plan
_____ Itemized Statement	_____Verbal Exchange of information regarding my treatment	
_____Collateral Sessions/Contact	_____ Other _____	

PURPOSE FOR USE OR DISCLOSURE: _____

I understand that LifeSkills is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee of LifeSkills to use or disclose my protected health information as described on this form to the recipients listed above. I understand that when information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I have the right to revoke this authorization at any time, if done so according to the steps set forth below. I also understand that I cannot be denied treatment for refusing to sign this authorization. You have the right to revoke this authorization at any time in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during an insurance contestability period. Unless another date/event/condition is specified, this release will expire in 60 days after the date it is signed:

_____

(Specification of the date, event, or condition upon which this consent expires)

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Prohibition on redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal Regulations (42 CFR PART 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5,000 in the case of subsequent offense.

_____ _____

Signature of Consumer Date Signature of Witness Date

_____ Whose relationship to the client is: ❒Parent ❒Guardian ❒Other_____

Signature of Parent/Representative Date

This form must be notarized if the signature is not witnessed by a LifeSkills staff member. A notary is not required when the signature is being witnessed by staff of an organization that has a business relationship with LifeSkills (school systems, medical facilities, Department of Protection and Permanency, courts, and jails).

Subscribed and sworn to before me this _____day of _____20_____.

NOTARY PUBLIC_____

My commission expires_____