AUTHORIZATION TO DISCLOSE INFORMATION

1. Client Name: ______________________ Social Security Number: ______________

   Date Of Birth: ______________________ Health Record ID#: ______________

authorize the use and disclosure of the listed individual's health information as described below. I understand that I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed.

2 **a. Disclosures by Seven Counties Services**

☐ **FROM** (List address of office)
Seven Counties Services
Addiction Recovery Center
600 S Preston St, Louisville KY 40202
(502) 583-3951

☑ **TO** (Full name and address of individual or agency)
RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054
SOUTHFIELD, MI 48086-5054
P:248-357-3330 F:248-357-3337

b. Disclosures to Seven Counties Services

☐ **TO** (List address of office)

☐ **FROM** (Full name and address of individual or agency)

3. I understand that the purpose of this disclosure is for:
   Use in future treatment
   ☑ Other (specify) LEGAL - DISCOVERY BEFORE TRIAL
   Please Call 248-357-3330 if there will be a charge for this information.

4. The type of information to be used or disclosed is as follows: (include dates where appropriate)
   ___ Initial Evaluation
   ___ Medical/Physical History
   ___ Psychiatric Evaluation
   ___ Laboratory Tests
   ___ History/Psychosocial
   ___ Treatment Plan
   ___ Medication History
   ___ Treatment Progress
   ___ Discharge Summary
   ___ Alcohol and Other Drug Use, Abuse, and/or Treatment Information
   ___ Treatment information which may include Human Immunodeficiency Virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), or Tests for HIV.
   ___ Other: ______________

5. Any person, insurer or third party who receives mental health or chemical dependency client information is prohibited by KRS 304.17A.555 from redisclosing that information without specific written consent of the patient. However, Seven Counties Services cannot prevent the redisclosure by the recipient, and the potential exists that information disclosed pursuant to this authorization will be redisclosed and no longer protected by HIPAA.

6. If the information being requested is from an alcohol or drug treatment case **42 C.F.R. Part 2, Confidentiality of Substance Use Disorder Patient Records** applies: This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any substance use disorder patient.

7. I understand that I have a 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 personnel. I understand that the revocation will not apply to information that has already been released in response to this authorization or information disclosed for the purpose of receiving reimbursement from a third party payer.

8. Unless otherwise revoked, this authorization will expire one year from date signed ______________ or after the following event has occurred or condition has been met Duration of Treatment.

____
Client / Personal Representative Signature Date

Personal Rep's Authority ☐ Parent ☐ Spouse ☐ Adult Child ☐ Other ______________

____
Staff Witness / Verification Date

☐ mail ☐ fax processed by ___________ date ______

REVOCATION OF AUTHORIZATION My signature in this space indicates that I have revoked this authorization to disclose form, and from this date information may not be release to the entity listed above without my resigned authorization. **Signature** ______________ **Date** ________