## Authorization for Release of Information

Client Name: ___________________________________________________________________________

Street Address: ___________________________________________________________________________

City, State, Zip: ___________________________________________________________________________

Birth Date: __________________________ Soc. Sec. No. _________________________________

Home Phone: ______________________________ Alternate Phone: ____________________________

I, _____________________________________________ authorize ASAP at Wilson Place__________________
to release information to:

KY Dept for Behavioral Health & Intellectual Disabilities
275 E. Main St. 4WG
Frankfort, KY 40621

Information to be ____mailed _____picked up. Date: ____________________

Type of information to be released:
All information in client's file______________________________________________________________

______________________________________________________________________________________________

Purpose of disclosure:
______________________________________________________________________________________________

The information may be communicated in the following manner: ☑Oral ☑Written

This authorization shall be in effect for 12 months or completion of services following the date of signature.

I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that the action has already been taken in reliance on it and that in any event this consent expires automatically as described above. I also understand Alcohol and Drug client records are protected by the Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations.

Signature of Client
Or Guardian__________________________________________________ Date: ______________

Relationship to client if unable to sign ______________________________________________________

Witness _______________________________________________
I authorize the release of the indicated sensitive records also (client to initial):
Mental Health Records...................................... __________ (initial)
HIV or AIDS ......................................................... __________(initial)
Chemical Dependency....................................... __________(initial)
DUI Records ........................................................ __________(initial)