stepworks recovery centers

Authorization for Release of Protected Health Information

Intensive Health a stepworks company

INSTRUCTIONS FOR COMPLETING THIS FORM

Complete all applicable sections.
Sign and date the form.

Please choose one:

Mail:

Stepworks
PO Box 6209
Elizabethtown, KY 42701-6209

Fax:

888-202-7866
ATTN: Medical Records

In person:

Take the completed form to the Stepworks facility
at which you were a patient.

If you would like to pick up the records at that same time,
please call the facility FIRST to arrange a time: (800) 545-9031

If you would like to pick your records up, we will only release your records to you or your legal representative.
A valid form of ID must be presented.

If this is not your first copy, a charge of $1/page will be required prior to releasing your records.

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Authorization for Release of Protected Health Information

Intensive Health a stepworks company

Patient Name: _____ Date of Birth:_____

SSN:_____ Phone Number:_____

□ London □ Elizabethtown-Woodland □ Elizabethtown-Crowne Pointe □ Bowling Green □ Nicholasville □ Intensive Health

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I authorize Stepworks Recovery Centers to:

□ **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 □ I will pick up

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Purpose of Request

□ Continuity of Care □ Insurance □ Referral □ Other: _____
□ Legal Circumstances □ Personal use □ Disability Determination □ Vocational Rehab □ Placement/Disposition

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Information Requested *(check all that apply)*

All information released may contain private health information related to substance abuse treatment.

□ Discharge Summary □ Progress Notes □ Treatment Plan □ Lab Results (except HIV/Hepatitis)
□ HIV and/or Hepatitis results □ Intake/Assessment □ Medical Tests/Studies □ Psychosocial Evaluation
□ Other: _____

I understand that I can revoke my consent at any time except when disclosure has already taken place, in which case consent will expire on _____ or 90 days from the date on which this form was signed. I understand my records may not be released to me at the same time as requested. I understand that I am entitled to one free copy of my medical record. *Any additional copies will be $1 per page.*

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.

Patient/Legal Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____

OFFICE USE ONLY:

Date request received:_____ Date records sent:_____ via □ fax □ certified mail □ pick-up
Signature and identifying information verified: □ Yes ID Verified if records were picked up: □ Yes Initials: _____
Printed name of staff member completing request: _____ Initials: _____

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). 42 CFR Part 2 prohibits unauthorized disclosure of these records.