RELEASE / REQUEST FOR HEALTH INFORMATION

____ ________________

PATIENT NAME **DATE**

I hereby consent and authorize:

RIDGE BEHAVIORAL HEALTH
3050 Rio Dosa Drive Lexington, KY 40509
Phone # 859-269-2325 **Fax # 859-268-6437**
RidgeHIM@uhsinc.com

TO:

☐ Release to/Receive from

☐

NAME:_______________________________________

Relationship to patient: _________________________

ADDRESS: ____________________________________

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____

PHONE #: ____________________________________

FAX #: ____________________________________

I understand that the information to be released includes information regarding **Medical, Mental Health, Chemical Dependency and HIV/AIDS** conditions.
I authorize the following information to be released/requested:

____ DISCHARGE SUMMARY
____ MEDICATION INFORMATION
____ LABS/X-RAY/EKG/MRI/EEG
____ VERBAL COMMUNICATIONS
____ PHYSICIAN OUTPT NOTES
____ PSYCHIATRIC EVALUATION
____ HISTORY/PHYSICAL EXAM
____ CONSULTATIONS
____ DATES OF SERVICE
____ OTHER (SPECIFY) ____________________

I AM AWARE THAT THESE DOCUMENTS WILL CONTAIN VERY DETAILED, SENSITIVE, INFORMATION ABOUT MYSELF OR THAT OF MY CHILD, INCLUDING: FAMILY HISTORY; LEGAL HISTORY; SOCIAL HISTORY; MEDICAL HISTORY AND TREATMENT HISTORY; AND HIV / AIDS

PURPOSE: I understand that the information will be used for:
_____ Further evaluation and treatment. (office use only______ FREE COPY)

_____ Other_______________________

I understand that my behavioral health treatment records (including drug and alcohol) and information are protected under the federal regulations governing Confidentiality and Behavioral Health Patient Records, 42 CFR, Part 2, and the HIPAA Privacy Rule, 45CRF, Parts 160 and 164, and cannot be disclosed without my written authorization, unless otherwise provided for by the regulations I hereby release both the above parties from any liability which may result form furnishing the information released or requested. Without my expressed **written** revocation, this consent will expire on _________________________________ from date signed.

_________________________________ __________ _________________________________ __________

Patient Signature (must sign if 16 or older) **Date** **Signature of Legal Guardian** **Date**
(For Minor or Incompetent Patients)

______________________ ________________ ______________________________

Patient SS# Date of Birth Witness Signature

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