PLEASE PRINT LEGIBLY

CABINET FOR HEALTH AND FAMILY SERVICES
COMMONWEALTH OF KENTUCKY
PROTECTION AND PERMANENCY

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
This form must be completed to authorize the disclosure of protected health information.

I HEREBY AUTHORIZE PROTECTION AND PERMANENCY IN THE DEPARTMENT FOR COMMUNITY BASED SERVICES IN THE CABINET FOR HEALTH AND FAMILY SERVICES TO DISCLOSE AND USE THE SPECIFIED INFORMATION BELOW.

Individual Requesting Records: Name (Print)	Address
City, State, Zip Code	
Telephone Number (Home)	(Work)
Please Send Records To: Name (Print)	Address
City, State, Zip Code	
Telephone Number (Home)	(Work)

The name of the individual whose information you authorize the disclosure of:

Social Security Number	Date of Birth
Case Record # (if known)	County where case record is maintained

The purpose for disclosure is:
(Note: Must complete, Do Not Leave Blank)

The specific Protected Health Information (PHI) you authorized the disclosure of:

☐ Medical History ☐ Immunizations ☐ Treatment Information ☐ Developmental Information ☐ Benefits Eligibility Records ☐ Payment Records ☐ Medicaid Claim Information ☐ Child Protective Services Information (Provide Court Custody Order or Court Order) ☐ Guardianship Information (Provide Court Custody Order or Court Order) ☐ Adult Protective Services Information (Provide Court Custody Order, Court Order, or Birth Certificate) ☐ Other_____

NOTE: Disclosure of psychotherapy notes must be authorized using form CHFS-305A, Authorization for Disclosure of Psychotherapy Notes

Please read carefully

- Complete this form within ten (10) days and mail to the **Cabinet for Health and Family Services, Department of Community Based Services, Records Management Section, 275 East Main St., Section 3E-G, Frankfort, Kentucky, 40621**
- I understand this authorization will expire in ninety (90) days.
- I understand I have the right to revoke this authorization at any time, however I must do so **in writing**. I further understand that actions already taken based on this authorization prior to revocation will **not** be affected.
- I understand I have the right to a copy of this authorization.
- I understand that authorizing the use/disclosure of PHI is voluntary. I need not sign this authorization in order to assure service. I may request to inspect or receive a copy of information to be used or disclosed, as provided in 45 CFR 164.524. I further understand that any disclosure of PHI carries with it the potential for an unauthorized disclosure and the information may not be covered by federal confidentiality rules. If I have questions about disclosure of PHI I can contact the Ombudsman's Office at (502) 564-5497 or the address listed above.
- I understand that information may be subject to re-disclosure and no longer protected.
- The following statement applies to any alcohol and/or drug abuse treatment information that we disclose. 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 further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure is **not** sufficient for this purpose.

My signature below acknowledges that I have read, understand and authorize the release of my PHI

Signature _____ Date_____

THIS FORM MUST BE COMPLETE