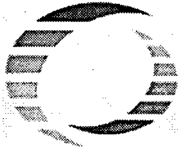

Neil Kennedy Recovery Centers®

Addiction Recovery & Self Renewal

Release of Information

Patient Name________________________________ DOB__________________ Client ID______________________

I hereby authorize NKRC to (select one):

☐Disclose Information
☐Receive Information
☐Exchange Information

Authorized individual/organization (Name & Title)____

Address of Authorized individual/organization____

Phone Number of Authorized individual/organization______________________ Fax Number___________________________

Purpose of Disclosure: ☐Health Insurance Billing/Authorization ☐Continuity of Care ☐Treatment Planning/Case Management ☐Continued Employment/Fitness for Duty ☐FMLA ☐Short Term Disability ☐Legal
☐OTHER – Specify____

Disclosure of information pertains to dates of treatment ranging: FROM (Date):______________Through (Date):________________

Act 148 Confidentiality of HIV-Related Information Act prohibits the disclosure of HI-related information without permission of the subject except in certain limited instances.

I consent to the disclosure of (please check all that apply):

☐Progress Notes ☐Diagnostic Assessment Information ☐Lab Results Urine Testing ☐HIV/AIDS Testing or Status ☐Pregnancy Testing ☐Prenatal Care ☐Diagnoses ☐Discharge/Summary Planning ☐Information on Mental Illness and/or Treatment ☐Medications ☐Insurance Cards ☐Immunization Records ☐Academic/School Records
☐Demographics ☐OTHER – Specify____
☐OTHER – Specify____

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent verbally or in writing at any time except to the extent that information has been released prior to the date of revocation by contacting Medical Records. **In any event, this consent shall expire one year from the date of signature.**

Unless I have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information permitted by this authorization in any manner that we deem to be appropriate and permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C. F. R. Part 2.

_______________________________ _______________

Patient Signature Date

_______________________________ _______________

Parent/Responsible Party Signature (If required) Date

_______________________________ _______________

Witness Signature Date

☐Copy Accepted ☐Copy Refused