Jackson Purchase Medical Associates
Authorization For Release of Information

_____ _____

Name Social Security #/ID #

_____ ***Dates of Treatment*/Service**

Birth Date From: _____

To: _____

The undersigned herby authorizes the release of information from the Medical Record of the above named individual (check appropriate box (es) :

☐ From ☐ To ☐ To ☐ From

Four Rivers Behavioral Health
Primary Care Integration Program
425 Broadway
Paducah, KY 42001
(270) 442-7142

Jackson Purchase Medical Associates (JPMA)
225 Medical Center Drive
Suite 201
Paducah, KY 42003
(270) 441-4200

Type of Information to Be Released:

___Admission Summary ___Progress Notes ___Treatment Plans ___Laboratory Tests ___Psycho-Social

___Psychological Eval ___Psychiatric Eval ___Current Medical Status ___Discharge Summary ___TX Summary

___**Drug/Alcohol Diagnosis, treatment and/or referral information**

___**Treatment Information which may include Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndrome (AIDS) or Tests for HIV.**

___**Other (specify)** Medical Records, Diagnosis (MH/SA), Recommendations, Test results, Drug Screen Results, Complete Clinics Patient Treatment Sheet

Purpose For Release: Provide Outpatient BH Assessment & Treatment at Clinic, Follow up with PCP/ARNP for continuity of care, schedule appointments

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Prohibition on Disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Law (42 U.S.C.290dd-22). Federal and State Regulations (42 C.F.R. Part 2) (KRS 304) prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 and KRS 304. The general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I am giving this consent voluntarily and have been informed that has been explained to me. I also understand that the provision of services is not contingent on my decision concerning this release of information.

Time Limitation of Release: This authorization expires on _____/_____/_____ (not to exceed one year). I understand this release is subject to revocation in writing at any time except to the extent that the program which is to make the disclosure has already taken action in reliance to it. I also understand that if the person (s) or entity (ies) that receive the information is not a health care provider or plan covered by general privacy regulations, the information relieved may be re-disclosed and is no longer protected by these regulations. I understand that I may inspect or request copies with any information disclosed by this restriction.

_____ _____
Signature of Consumer Date

_____ _____
Signature of Consumer's Parent / Legal Guardian Date

_____ _____
Witness Date

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Revocation of Release: _____ _____
(Date Revoked) Signature of Consumer, parent, guardian