Free To Be Mental Health Services, LLC
851 Corporate Dr, Ste 250
Lexington, Kentucky, US - 40503

AUTHORIZATION TO RELEASE MEDICAL RECORDS for Free To Be Mental Health Services, LLC

This document must be written, dated, and signed by the patient or a legally-authorized person.

Patient Legal Name: *

Date of Birth: *

I authorize:

Name, address, and phone number of clinic/provider authorized to release medical records: *

To release a copy of the medical information specified below to:

Name, address, and phone number of clinic/provider authorized to receive medical records: *

Requested time period: Last 2 years (default) or Dates of Service:

This information will be used on my behalf for continuity of care (default) or the following purposes:

I specifically authorize the release of the following medical records and personal health information, if such records exist: *

- ☐ All hospital records
- ☐ Records needed for continuity of care
- ☐ Emergency and Urgent care records
- ☐ Clinician office chart notes
- ☐ Laboratory reports
- ☐ Pathology reports
- ☐ Diagnostic imaging reports
- ☐ Entire medical record

The following items require a specific authorization and must be INITIALED to be included in the use or disclosure of other medical informaition

- ☐ HIV/AIDS test or result information and/or records
- ☐ Mental health information and/or records
- ☐ Genetic testing information and/or records

INITIALS: *

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For drug/alcohol diagnosis, treatment, or referral information, federal regulations require a description of how much and what kind of information is to be disclosed/ If applicable, please describe:

I have reviewed and understand this authorization. I also understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. However, I also understand that federal and state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

INITIALS: *

You do not have to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance where refusal to sign means you will not receive care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

INITIALS: *

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing on (insert applicable date or event).

INITIALS: *

PATIENT SIGNATURE or legal representative *

Date *

Print name of person signing this form (and relationship, if other than patient) *