Intensive Health
a stepworks company

201 Peterson Drive, Elizabethtown, KY 42701
Phone: (270) 765-5900 | **Fax**: (859) 878-1024

Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: ____ / ____ / _____

Social Security Number: _____ - _____ - _____ Phone Number: _____

I authorize Intensive Health, a Stepworks company, to:

CHECK ONE: ▢ **RELEASE** Medical Records to: ▢ **OBTAIN** Medical Records from:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I request that my records be: ▢ faxed ▢ certified mailed to person/entity above ▢ picked up in person (ID required)

_____ Initials

I request my medical records be sent via unencrypted email. I understand that email is not secure, and any email or email attachment could be intercepted or read by a third party. (If you do not initial, your records cannot be sent via email.) **Email address:** _____

I authorize the release or disclosure of the following records:

▢ **ALL MEDICAL RECORDS** including any information related to the diagnosis and treatment of alcohol or drug abuse (SUD), mental health, hepatitis, STDs, and/or HIV/AIDs

▢ **OR** the following **SPECIFIED** records (check all that apply):

- ▢ medical provider and nursing/staff notes
- ▢ medication list
- ▢ all lab results
- ▢ radiology and other diagnostic testing
- ▢ Stepworks residential episodes
- ▢ other _____
- ▢ therapist and peer support specialist notes
- ▢ treatment plan
- ▢ biopsychosocial assessments
- ▢ Stepworks sober living episodes
- ▢ Stepworks outpatient episodes (PHP/IOP)

I should not have records relating to the following and/or do NOT wish to release the following information:

- ▢ Records relating to HIV/AIDs
- ▢ Records about substance use
- ▢ Records about STDs and/or hepatitis
- ▢ Records about mental health

Dates of Information to be Disclosed

▢ all dates of service ▢ the last year ▢ from ____ / ____ / _____ to ____ / ____ / _____

Purpose of Disclosure

- ▢ personal
- ▢ legal circumstances
- ▢ continuity of care
- ▢ referral
- ▢ disability determination
- ▢ other (specify): _____

I understand that I can revoke my consent at any time by speaking to an Intensive Health staff member, except when disclosure has already taken place, in which case my consent will expire 60 days from the date this form was signed. You are entitled to one free copy of your medical records. Additional copies are $1 per page.

42 CFR Part 2 prohibits unauthorized use or disclosure of these records.

Patient/Legal Representative Signature: _____ Date: ____ / ____ / _____

Witness Signature: _____ Date: ____ / ____ / _____