PATIENT CONSENT AND AUTHORIZATION FORM FOR DISCLOSURE OF CERTAIN HEALTH INFORMATION TO THE KENTUCKY HEALTH INFORMATION EXCHANGE

****PLEASE READ THE ENTIRE FORM BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last):_____
Date of Birth (mm/dd/yyyy): _____
Address: _____
City: _____ State: _____ Zip: _____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize access, use and disclosure of my health information:

DISCLOSURE:
Check all of the boxes to identify the information you authorize to disclose:

❑ Drug or alcohol abuse treatment information (if any) or mental health treatment information (if any)

FROM WHOM: Specific name or general description or organization(s) who I am authorizing to release my information under this form: _____

❑ All programs in which the patient has been enrolled as an alcohol or drug abuse patient (if any) and as a mental health treatment patient (if any) that is affiliated with the Kentucky Health Information Exchange.

TO WHOM: Specific person(s) or organization(s) permitted to receive my information: _____
_____

❑ I authorize any current and future health care providers/organizations that are treating me or are involved in the coordination of my health care to access any and all of my health information through the Kentucky Health Information Exchange (KHIE). Please see the attached listing for a list of Kentucky Health Information Exchange (KHIE) healthcare providers. You can also go to www.KHIE.ky.gov for an updated listing of Kentucky Health Information Exchange (KHIE) providers.

Amount and Kind of Information: The information to be released may include but not be limited to: Patient Demographics, Vital Signs, Problems and Diagnoses, Insurance Information, Health Care Providers, Laboratory Results, Medications, Medical Care & HIV/AIDS, Alcohol & Substance Abuse and Mental or Behavioral Health information.4230

PURPOSE: The information shared will be used:

- To help with my Treatment and Care Coordination
- To assist the provider or organization to improve the way they conduct their work
- To help pay for my Treatment

EFFECTIVE PERIOD: This authorization/consent/permission form expires:

Leave blank to default to one year OR enter date ____/____/____.

If there is no date entered, the consent will be valid for one year from the date this form is signed.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom" or "From Whom" sections except to the extent the disclosure agreed to has been acted on.

In addition:

- I understand that an electronic copy of this form can be used to authorize the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons according to state or federal law.
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

"**This Health Information Exchange (HIE) consent does not permit use of my protected health information in any criminal or civil investigation or proceeding against me without an express court order granting the disclosure unless otherwise permitted under state law."**

X _____ _____
Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

_____
Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

❑ Parent of minor
❑ Guardian
❑ Other personal representative (explain: _____

NOTE: *Under some state laws, minors must consent to the release of certain information. The law of the state from which the information is to be released determines whether a minor must consent to the release of the information.*

This form is invalid if modified. You are entitled to get a copy of this form after you sign it.