LINCOLN TRAIL BEHAVIORAL HEALTH SYSTEM
RELEASE OF PHI (PROTECTED HEALTH INFORMATION) AUTHORIZATION

TO/FROM Lincoln Trail Behavioral Health
3909 S. Wilson Rd.
Radcliff, KY 40160
Phone #: 270-351-9444

TO/FROM _____
_____
_____
Phone #: _____

PATIENT NAME: _____ **DATES OF TREATMENT:** _____

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____

Type of Patient Identifiable Health Information:

☐ Discharge Summary ☐ Psychiatric Evaluation ☐ History and Physical
☐ Lab Result ☐ Psychological Evaluation ☐ Other (specify) _____

I hereby authorize the release of my protected health information indicated to the individual listed and understand that "minimum necessary" rule will apply. I understand that my signature on this form will not affect my condition for treatment, payment, enrollment, or eligibility pertaining to benefits. ***Faxed information will be limited to pertinent clinical information.***

"At the request of the Patient/Patient's Representative" Purpose of Release:

☐ Legal Circumstances ☐ Vocational Rehabilitation ☐ Other (specify)_____
☐ Continuity of Care ☐ Disability Determination
☐ Placement/Disposition ☐ Insurance Purposes ☐ Individual elects not to state purpose

I understand that I can revoke my authorization in writing at any time with the exception that the revocation will not apply to information already released in response to this authorization. If not previously revoked this authorization will expire on _____ or 90 days from date signed.

PROHIBITION ON DISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or 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.

_____ _____
Witness Signature of Patient or Patient's Representative

_____ _____
Date Relationship to Patient

For Office Use Only: ☐ **ID Verified**

Physician's Signature: _____ Date: _____