Summit Health, LLC
3150 Custer Drive, Suite 201
Lexington, KY 40517
Phone: 859-229-0085 / Fax: 859-273-6778

AUTHORIZATION FOR DISCLOSURE OF PATIENT MENTAL HEALTH RECORDS

All Sections of this Form Must be Completed Before Records Will Be Disclosed

Patient Name: _____ **Social Security #:** ___-___-____

Address: _____ **Date of Birth:** ___/___/____

City: _____ **State:** _____ **Zip:** _____

Home Phone: ___-___-____ **Work Phone:** ___-___-____ **Cell Phone:** ___-___-____

AUTHORIZATION: I, the above-named Patient or Personal Representative of said Patient, hereby authorize Summit Health, LLC to disclose the mental health records and information which I have designated below for the dates of: _____ through _____ to the following:

Name: _____

Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Phone No. ___-___-____ **Fax No.** ___-___-____

Relationship to Patient: _____

I understand that Summit Health, LLC is a provider of mental health and related medical care, and that its patient records contain sensitive information pertaining to the diagnosis and treatment of mental health conditions and other sensitive personal information protected by HIPAA and other privacy laws. I also understand that Summit Health keeps its Providers' psychotherapy notes regarding a patient separate from the patient's health records due to the special privacy protections afforded to psychotherapy notes under HIPAA. For this reason, this Authorization does include disclosure of psychotherapy notes. Summit will only disclose psychotherapy notes regarding a patient under a separate signed authorization limited to psychotherapy notes. I further understand that if the records I have designated for disclosure below include Substance Use Disorder treatment records and/or sensitive information concerning the diagnosis and treatment of a sexually transmitted disease ("STD") or other communicable disease (e.g., AIDs, HIV), I have the right in this Authorization to expressly EXCLUDE those records from disclosure. Considering all of the above, I authorize the following records to be disclosed:

☐ **ENTIRE RECORD**

OR

ONLY THE RECORDS CHECKED BELOW

☐ Mental Health Treatment Records

☐ Prescription Records

☐ Psychological Tests

☐ Laboratory / Other Diagnostic Tests

☐ Billing and Insurance records

I direct Summit Health, LLC to **EXCLUDE** the following from the records I am authorizing to be disclosed:

☐ Substance Use Disorder Treatment Records

☐ STD/Communicable Disease Records/Information

If the above-named recipient of the Patient's records is not the Patient, do you authorize the Patient's treating provider with Summit Health to discuss the Patient's treatment with the recipient? ☐ YES ☐ NO

Purpose of Disclosure: ☐ Patient request ☐ insurance reimbursement ☐ continuity of care by another treating provider ☐ legal (attorney) other (please specify): _____

Form of Disclosure: ☐ Hard copy ☐ Facsimile transmission ☐ Encrypted electronic file

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Hard copies must be picked-up in person – photo ID is required at time of pick-up. If Summit cannot confirm that facsimile or electronic transmission of the Patient's record is to a secure location, a hard copy will be made for in-person pick-up instead.

Patient Rights: I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment from Summit Health. I have a right to a copy of this Authorization. If have authorized disclosure of the Patient's health records to a recipient other than myself, I may obtain a copy of the disclosed records subject to the copying charges set forth below. I may revoke this Authorization at any time, unless the Authorization was obtained as a condition of obtaining insurance coverage. If I wish to revoke this Authorization, I must submit my revocation in writing directly to Summit Health LLC at the address first given above. I understand that the revocation will be effective when received by Summit Health, LLC except for information which Summit Health, LLC has already disclosed in reliance on this Authorization.

Potential Redisclosure. I understand that Summit Health (including its employees) are responsible to maintain the confidentiality and privacy of patient health care records and information in its possession. I acknowledge that if I have named a recipient of the records/information in this Authorization that is not a health care provider or health insurer, the recipient is not bound by federal or state health information privacy laws to maintain the confidentiality of the disclosed records/information. I also acknowledge that once Summit makes the authorized disclosure, the recipient may redisclose it to third parties with or without the Patient's knowledge or permission. In the event of a redisclosure, I agree that the Summit Health LLC, its employees, officers and agents are not legally responsible or liable for any consequences arising from the redisclosure or from any improper use of the disclosed records/information by the recipient or others, and I release each and all of them from any such responsibility or liability.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

Date:_____

_____
Patient Signature

_____
Legal Representative Signature*

Print name:_____

Relationship to Patient: _____

**Proof of designation must be attached – see p. 3*

This Authorization will expire on _____. If no date is provided, this Authorization will expire in 90 days from the date of signature.

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AUTHORIZATION FOR DISCLOSURE OF PATIENT MENTAL HEALTH RECORDS

ATTENTION PATIENTS AND PERSONAL REPRESENTATIVES
Facts About Obtaining Patient Mental Health Records

1. Patients have the right to a copy of their health records. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy laws require Summit Health, LLC to obtain this signed Authorization before disclosing a Patient's record or protected health information in the record ("Health Information") to anyone except the Patient. It is Summit Health's Policy to also require Patients to sign this Authorization form before Summit Health will provide a copy of their health record directly to the Patient to ensure Summit has documentation of the records disclosed to the Patient. For regulatory compliance purposes, Summit Health, LLC does not accept third party release authorizations. The first two pages of this Authorization must be fully completed and signed before Patient records will be disclosed.

2. Personal Representatives. A Personal Representative is an individual who has legal authority to make health care decisions for the Patient. An immediate family is not a Patient's Personal Representative simply by reason of their relationship. Summit Health will only disclose a Patient's records/ information to an immediate family member if the Patient has completed and signed this Authorization form designating the family member as the recipient, or verbally authorized their Summit Health Provider to disclose specific information or records to the family member, or the Patient is present when the disclosure is to be made to the family member and does not object to the disclosure. When a Patient is unable to agree to disclosure of their health record/information, Summit Health has discretion to disclose to a family member/friend who is reasonably directly involved in the Patient's care if in the Provider' professional judgment, the disclosure is in the Patient's best interest. In such cases, the disclosure will be limited to health records/information directly relevant to the person's involvement in the Patient's care or payment for care. Non-family members must verify to Summit that they have the legal authority to act for the Patient in health care matters in order to sign this Authorization on the Patient's behalf. Acceptable proof of legal authority requires a valid photo-ID, and one of the following: (a) the Patient's currently in force Power of Attorney naming the individual as the Patient's attorney-in-fact with authority to make health care decisions for the Patient; (b) a court order appointing the individual as the Patient's legal guardian or personal conservator with authority to make health care decisions for the Patient; or (c) in the case of a deceased Patient, a court order appointing the individual as the Executor or Administrator of the Patient's probate estate.

3. Records Pick-up. The Patient or their Personal Representative signing this Authorization must present a photo-ID to Summit when picking-up the Patient's records at Summit Health's office.

4. Electronic Health Records. If we are unable to determine that a Patient's electronic health records will be received by the authorized recipient at a secure location, the Patient or their Personal Representative must pick the records up from Summit in person.

COSTS:
Kentucky law allows a Patient **one free copy** of his/her health record, whether the Patient requests the copy for his/her own use or to give to a third party. Summit Health, LLC charges $1.00 per page for each additional copy requested. We encourage Patients to keep a personal copy of any records disclosed under this Authorization to avoid incurring copying fees for additional copies.

WHEN AND HOW WILL I GET MY RECORDS?
Requests will be completed within **30 days** of receipt. You will be notified via mail if the records cannot be processed in 30 days. Records will be delivered as indicated on the request. If you are picking up your records, please note that they will only be held for **30 days** once notice has been made that they are ready for pick-up. If they are not picked up within **30 days of the date of the notice,** the copies will be destroyed, a new Authorization will have to be completed, and you will be charged for copies. It is very important that you provide the best phone number at which to reach you so that we may call you when the records are ready for pick-up.