Medicaid #

Birthdate _

Insurance #

AUTHORIZATION TO SHARE INFORMATION

1. I authorize Transformations & its repres		
4010 Dupont Circle Suite 582	Contact information	
Louisville KY 40207		
Phone & fax 502-899-5411		
Secure email: office@transformationsllc.r	net	

To share with one another the following items from my Protected Health Information: Psychological, psychiatric, clinical, medical and educational evaluations, records, progress summaries, contact logs, treatment plans, and progress updates both written and verbal. Other:

I understand that the purpose of sharing this information is for:

2. I understand that I may refuse to sign this authorization and that Transformations, LLC and its Contractors will not allow my refusal to interfere with the receipt or payment of behavioral health services.
3. I understand that I may revoke this authorization, at anytime, in writing to Transformations at the address indicated below, except if Transformations or its Contractor has taken any action based on prior authorization, or obtained my authorization for the purpose of receiving reimbursement from a third party.
4. This authorization will expire on _______, or immediately following the revoking of the authorization, or after the following event has occurred if this is a one time release
5. I understand that pursuant to KRS 304.17A-555-Patient's Right of Privacy Regarding Mental health or Chemical Dependency-Authorization Disclosure, my Protected Health Information, used and /or shared under this authorization may not be shared by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the re-disclosure.
6. I understand that pursuant to 45 CFR 46.101(b.2) only data that has been separated from my child's identifiable information may be used for research and program development purposes, unless written consent by signing this form is provided.

I have read and understand this authorization.

Consumer/Guardian if Client is under 18

Date

Relationship to Client

Witness

Date