

AUTHORIZATION TO SHARE INFORMATION

Applicant Name Shenika	Breed	Birth Date <u>7- 25-77</u>
I, Shenika Breed	a	uthorize Transformations, and
Reference Name: Hicholas Address: Nwbloodworth	Bloodworth e campbells	ville, edu
To share with one another the followersonal impressions of work and o		
I understand that the purpose of shareference.	ring this inform	nation is for contract employment
This authorization will expire on the revoking of the authorization, or one time release.	r after the follow	, or immediately following ving event has occurred if this is a
I understand that pursuant to KRS 3 Mental health or Chemical Depende Health Information, used and /or sha the recipient of the information bey- given, without first obtaining my sp	ency-Authorizat ared under this ond the purpose	tion Disclosure, my Protected authorization may not be shared by for which my authorization was
I have read and understand this auth	norization.	
Sherika Breed Printed Name		
Witness/date		



AUTHORIZATION TO SHARE INFORMATION

Applicant Name Shenika Breed Birth Date 7-25-77
I, Shenika Breed authorize Transformations, and
Reference Name: <u>Likki Erwin</u> Address: <u>neerwing campbellsville.edu</u>
To share with one another the following items: work history, current employment, personal impressions of work and other information needed from Transformations.
I understand that the purpose of sharing this information is for contract employment reference.
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.
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.
I have read and understand this authorization.
Signature/date
Shenika Breed Printed Name
Witness/date



AUTHORIZATION TO SHARE INFORMATION

Applicant Name Shenika Breed Birth Date 7-25-77
I, Shenika Breed authorize Transformations, and
Reference Name: Mary Badami Address: Mbadami & campbellsville, edu
To share with one another the following items: work history, current employment, personal impressions of work and other information needed from Transformations.
I understand that the purpose of sharing this information is for contract employment reference.
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.
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 be 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.
I have read and understand this authorization.
Signature/date Shenika Breed Printed Name
Witness/date