Transformati

AUTHORIZATION TO SHARE INFORMATION

Applicant Name Susan Andersen Birth Date 6/15/1969

I, Susan Andersen authorize Transformations, and

Reference Name: Elizabeth Long
Address: 1577 Washburn Rd.
Shelbyville, KY 40065

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 1/27/2023, 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] 1/27/2022
Signature/date

Susan Andersen
Printed Name

[signature] 1/27/2022
Witness/date

Transformati

AUTHORIZATION TO SHARE INFORMATION

Applicant Name Susan Andersen Birth Date 6/15/1969

I, Susan Andersen authorize Transformations, and

Reference Name: Shannon Cook

Address: 5103 Fox Run Rd
Buckner, KY 40010

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 1/27/2023, 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 1/27/2022

Printed Name Susan Andersen

Witness/date 1/27/2022

Transformati

AUTHORIZATION TO SHARE INFORMATION

Applicant Name SUSAN Andersen Birth Date 6/15/1969

I, SUSAN Andersen authorize Transformations, and

Reference Name: LISA Prewitt

Address: PO BOX 155, 679 N. Main St.
New Castle, KY 40050

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 1/27/2023, 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.

1/27/2022
Signature/date

SUSAN Andersen
Printed Name

1/27/2022
Witness/date