Kentucky Counseling Center

Consent to Release Private Health Information

Kentucky Counseling Center, LLC Fax-502-631-9660, Phone-855-591-0092

Client's name *

First Name Last Name

Birthday *

Month Day Year

Please release the following documents: *

- ☐ All medical records
- ☐ Treatment Plan
- ☐ Psychotherapy Notes
- ☐

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Kentucky Counseling Center, LLC. I understand that a revocation is not valid to the extent that Kentucky Counseling Center, LLC has acted in reliance on such authorization. A copy of this release shall have the same force and effect as the original.

NOTICE TO RECEIVING PARTY: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for disclosure of this information by the recipient, and if that occurs, federal law may not protect the information.

I consent for Kentucky Counseling Center, LLC and those representing this group to share my private health information with the following individuals and/or entities. KCC is permitted to send and receive information to and from those named below: *

- ◯ Other health care provider
- ◯ Emergency contact
- ◯ Attorney
- ◯ School representative

- ◯ Parent or Guardian
- ◯ _____

Name or entity of the party listed above: *

_____

Guardian's name with the legal authority to make medical decisions on behalf of the client if applicable *

_____ _____

First Name Last Name

Signature of client or guardian with medical decision making authority

_____