SULLIVAN LAW OFFICE
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MICHAEL P. SULLIVAN

Attorney at Law

AUTHORIZATION TO DISCLOSE INFORMATION

1. **Client Name**: ________________________________ **Social Security #:** __________________

   Date of Birth: ___________ Health Record ID#: __________________

2. 1 hereby authorize_____________________________________to disclose my health information as described below to *Attorney Michael P. Sullivan, 1500 Story Avenue, Louisville, KY 40206.* I also understand that I may inspect or copy the information to be used or disclosed.

3. 1 understand that the purpose of this disclosure is for ____ Social Security Disability Claim
   ____ Long/Short Term Disability Claim
   ____ Kentucky Retirement Claim
   ____ Other (specify) ____

   Name: ___________________________
   Add: ___________________________
   City: ___________________________
   State: _______ ZIP : ______

4. The type of information to be used or disclosed is as follows: (include dates where appropriate)

   ____ Initial Evaluation ____History/Psychosocial ____Admission History
   ____ Progress/Treatment notes ____ Psychiatric Evaluation ____Discharge Summary
   ____ Special Test/Lab results ____Medication History ____Operative Report
   ____ E/R Summaries

   ___Alcohol and Other Drug Use, Abuse, and/or Treatment Information: ¯Treatment Information which may include Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndrome (AIDS), or Tests for HIV.
   Other.____

5. I understand that pursuant to KRS 304.17A-555-Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure, my Protected Health Information, used and or disclosed under this authorization may not be shared again 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. If the information being requested is from an alcohol or drug treatment case, 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records applies: This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that other information, not alcohol or drug related, may be used or disclosed pursuant to this authorization and subject to re-disclosure by the recipient and may no longer be protected by federal laws and regulations regarding the privacy of my protected health information.

7. I understand that I have a right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and present my written revocation to the health information management personal. I understand that the revocation will not apply to information that has already been released in response to this authorization or information disclosed for the purpose of receiving reimbursement from a third party payer.

8. Unless otherwise revoked, this authorization will expire one year from date signed or after the following event has occurred or condition has been met. I ATTEST THAT A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL.

9. I understand that pursuant to KRS 422.317, a hospital licensed under KRS Chapter 216B or a health care provider shall provide, without charge, one free copy of the patient's medical records. By signing this release, I am giving this office permission to obtain my free copy of medical records.

I understand that I do not need to sign this Authorization in order to ensure medical treatment, payment, enrollment in my health plan, or eligibility for benefits.

______________________________	__________	______________________________	__________
Signature Client/Personal Representative	Date	Witness	Date