EMERALD THERAPY CENTER, LLC.

5050B Village Square Dr, Paducah, KY/ 2327 New Holt Rd, Paducah, KY/ 111 Poplar St, Murray, KY/
1019 Paducah Rd, Mayfield, KY / 1640 McCracken Blvd, Paducah, KY 42001

AUTHORIZATION FOR RELEASE OF INFORMATION

INCLUDING MENTAL HEALTH, ALCOHOL OR DRUG ABUSE INFORMATION

Name of Patient: _____ DOB: _____

Address: _____

I (WE) hereby authorize **Emerald Therapy Center, LLC** **Ph: 270-534-5128**
Fax: 270-477-0007

To ☐ **Release** ☐ **Exchange** ☐**Receive** records or information as requested below:

Agency/Person to release/receive: _____

Address: _____

_____

Specific Nature of Information to be disclosed - Please initial or place check mark by each requested item:

_____ Initial Psychiatric History/Evaluation
_____ Psychological Reports/Evaluations
_____ Lab/X-ray/Test Results
_____ Consultations
_____ Other _____
_____ Progress Notes
_____ Complete Medical Record
_____ Financial Information
_____ Contact/Discuss Treatment and Progress
_____ All information

For the purpose of: (Please check all that apply)

_____ Continuing (mental health/alcohol or drug abuse) treatment, care and continuity of care
_____ Therapist transition
_____ Other _____
_____ Billing and payment related matters
_____ Legal

This consent is **VALID FOR ONE YEAR FROM DATE SIGNED** (unless otherwise specified). Other Date:_____.
I understand that I may revoke this authorization by notifying ETC at 5050B Village Square Dr., Paducah, KY 42001 in writing of my desire to revoke release prior to its expiration except to the extent that action has already been taken by ETC in reliance on the consent. I understand that ETC **may not condition treatment** or quality of care upon completion of this form. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization which will **prevent disclosure of information.** I understand that ETC may, directly or indirectly, receive remuneration from another party in connection with the use of release of disclosed health information . I understand that I also will be charged for review and copying of records. I understand that information disclosed may be subject to re-disclosure by the person(s) receiving it and will no longer be protected by the federal privacy regulations.

I have read and understand the terms of this authorization and release and have had an opportunity to ask questions about the use and disclosure of my health information. By signature, I knowingly and voluntarily authorize ETC to use and disclose my health information in the manner described above.

_____/_____ _____/_____
Patient Signature Date Witness Date

_____/_____ _____/_____
Parent/Legal Guardian Signature Date Witness Date

NOTICE TO PATIENT AND RECEIVING AGENCY:
Under the provisions of the Mental Health and Developmental Disabilities Act and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be disclosure of any of the information provided pursuant to this release unless the patient and /or parent of the patient specifically authorizes such disclosure.