Astra Behavioral Health, LLC

Release of Protected Health Information

PATIENT INFORMATION

FIRST NAME	MI
LAST NAME	
DOB	SOCIAL SECURITY NUMBER

Disclosure of the patient's PHI	☐ TO ☐ FROM	Disclosure of the patient's PHI	☐ TO ☐ FROM
Person, class of persons, or organization **Astra Behavioral Health, LLC**		Person, class of persons or organization	
1013 Granite Drive Bardstown, KY 40004 T: (502) 349-3100 F: (502) 349-3169 ☐	2000 Ring Road Elizabethtown, KY 42701 T: (270) 506-2730 F: (270) 900-0704 ☐	Address	
129 Parkway Drive Bardstown KY, 40004 T: (502) 233-9696 F: (502) 373-1648 ☐	420 N Loretto Road Ste 200 Lebanon, KY 40033 T: (270) 321-4480 F: (270) 321-4490 ☐	City	State / ZIP
		Phone	Fax

TYPE OF IDENTIFIABLE PATIENT HEALTH INFORMATION		PURPOSE OF RELEASE	
DATES OF SERVICE:			
Initial Evaluation with Psychiatrist	☐	Continuity of Care	☐
Initial Evaluation with Therapist	☐	Disability	☐
Physician Progress Notes	☐	Legal Circumstances	☐
Legal Circumstances	☐	Placement/Disposition	☐
Placement/Disposition	☐	Vocational Rehabilitation	☐
Individual Elects Not to State Purpose	☐	Individual Elects Not to State Purpose	☐
Other (specify below) ____________________	☐	Other (specify below) ____________________	☐

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 shared 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 re-disclose. Additionally, I understand that my information prohibits the recipient to further disclose any information without written consent unless otherwise permitted by Federal Law 42 CFR Part 2. I am aware that if the person or entity that receives this information is not a healthcare provider or plan covered by federal privacy regulations, this information may be re-disclosed and no longer be protected by these regulations.

I understand that medical records released pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions and/or blood borne infectious diseases, which are subject to federal and/or state restrictions on disclosure. The federal regulations restrict any use of protected health information to criminally investigate or prosecute any alcohol and/or substance use patients.

I understand I have the right to revoke this authorization in writing to an Astra Behavioral Health location listed above at any time with the exception that the revocation will not apply to information already released in response to this authorization. Furthermore, per 94 HC250, I am entitled to one (1) free copy of my medical record. Additional requests may be subject to fees. I understand that in any and all authorized releases of information, the "minimum necessary" rule will apply. I understand that my signature on this form will not affect my condition for treatment, payment, enrollment or eligibility pertaining to benefits.

SIGNATURE OF PATIENT OR REPRESENTATIVE	DATE
RELATIONSHIP TO PATIENT (IF REPRESTNATIVE)	WITNESS

ORIGINAL