

AUTHORIZATION FOR RELEASE OF INFORMATION

1. THE UNDERSIGNED HEREBY AUTHORIZES:

The Scott Group, PLLC
PO BOX 917
Frankfort, KY 40602

TO RELEASE INFORMATION FROM THE MEDICAL (HEALTH) RECORD OF:

(NAME)

(ID NUMBER)

(BIRTH DATE)

(DATES OF TREATMENT/SERVICE)

2. INFORMATION TO BE REALEASED TO: _____
(Person/Agency/Address)

3. TYPE OF INFORMATION TO BE REALEASED: _____

4. PURPOSE FOR RELEASE: _____

5. It is understood that this authorization for release is subject to revocation at any time, and that unless another date is specified this release will expire sixty (60) days after date it is signed.
TIME LIMITATION OF RELEASE: _____

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PROHIBITION ON REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IF HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO VIOLATES ANY PROVISION OF THIS LAW SHALL BE FINED NOT MORE THAN \$500, IN THE CASE OF A FIRST OFFENSE, AND NOT MORE THAN \$5,000 IN THE CASE OF EACH SUBSEQUENT OFFENSE.

Date

Signature of Patient/Resident/Client

Witness

Signature of Patient's/Resident's/Client's
Agent or Representative

Expires

Relationship

Address