Knowles-Duncan & Associates, LLC

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ **D.O.B.** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

I hereby request Knowles-Duncan & Associates, LLC to: [ ] RELEASE to & OBTAIN from [ ] RELEASE to [ ] OBTAIN from

Person/Organization: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **E-Mail:** _____

Information Requested:
[ ] Entire Patient Record
[ ] Alcohol/Drug Evaluation
[ ] Other:
[ ] School Records
[ ] Diagnosis & Evaluation
[ ] Discharge/Termination
[ ] Psychological Testing

Purpose of Release: **[ ]** Treatment **[ ]** Other: _____

I understand that this request will be valid for one hundred eighty (180) days from the date written below. At that time the request will be void and no further information will be furnished pursuant to it.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Knowles-Duncan & Associates, LLC. I understand that a revocation is not effective to the extent that Knowles-Duncan & Associates has relied on the use or disclosure of the protected health information.

This release prohibits re-disclosure except in accordance with 42 C.F.R., 21 et seq., which is a federal regulation governing release and use of patient record information pertaining to treatment for alcohol and drug abuse.

Knowles-Duncan & Associates, LLC will not condition my treatment whether I provide authorization for the requested use or disclosure.

I agree to pay Knowles-Duncan & Associates, LLC an actual cost incurred in preparing and delivering the information requested herein.

A copy of this authorization shall be as valid as the original.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Relationship to Patient

WITNESS: _____

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