Comprehend, Inc.
Your Community Source for Mental Wellness

Our Mission: To enhance the well-being of the individuals, families and communities we serve by advocating for and providing behavioral healthcare services in a welcoming and caring environment.

Authorization for Release of Information

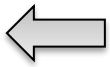
_____ _____ _____
Full Name of Client | Social Security or other ID # | Date of Birth

I authorize and give this consent voluntarily. I have been informed of the specific type of information that has been requested and the benefits and disadvantages of releasing that information has been explained to me. I also understand that the provision of services is not contingent on my decision concerning this release of information.

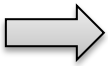
_____
Print Name of Other Party

_____
Other Party Address

_____
Other Party City/State/Zip



To/From



Comprehend, Inc.
611 Forest Avenue, Maysville, KY 41056

TYPE OF INFORMATION TO BE RELEASED: (initial all that apply)

___ History & Physical ___ Progress Notes ___ Psychosocial Evaluation ___ Psychiatric Eval.

___ Treatment Plans ___ Drug/Alcohol Information ___ Psychological Eval ___ Laboratory Tests

___ Current Medical Status ___ Discharge Summary ___ Gene-related impairments (including genetic test results)

___ Treatment Information which may include Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS) or Tests for HIV. ___ Summary of Diagnosis ___ Treatment Goals

___ Date and Time of Treatment: _____ ___ Verbal & Written Communication

___ Other (specify) _____ ___ Results of Academic Testing

_____ ___ Discipline Reports to provide off-site school based therapy if needed

AMOUNT OF INFORMATION TO BE RELEASED:

___ Information covering the most recent admission

___ Other time frames: (specify) _____

___ To obtain collateral information

PURPOSE FOR RELEASE:

___ Report consumer progress

___ Verify consumer attendance

___ Other (specify) _____

TIME LIMITATION OF RELEASE: This authorization expires in 1(one) year or _____.

I understand that pursuant to KRS 304.17A-555-Patients Right to Privacy Regarding Mental Health or Chemical Dependency – Authorized Disclosure, my Protected Health Information, used, shared or requested under this authorization may not be redisclosed by the recipient of this information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the redisclosure. *42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

PROHIBITION ON REDISCLOSURE:

I have read and understand this authorization.

_____ _____ _____ _____
Signature of Consumer, Parent or Legal Guardian | Date | Witness | Date

REVOCATION OF RELEASE:

This release is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it.

_____ _____ _____ _____
Signature of Consumer, Parent or Legal Guardian | Date | Signature of staff releasing information | Date

Specific Information released: _____
(Completed by staff, if information has been released)