


## PROVIDER TRAINING

### COMPLETE A RELEASE OF CONFIDENTIAL INFORMATION FORM



#### KEPRO: AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

1 Member Name: \_\_\_\_\_ 1 DOB: / / \_\_\_\_\_ 1 SSN: \_\_\_\_\_ - - \_\_\_\_\_

2 \_\_\_\_\_, hereby authorize 3 \_\_\_\_\_  
(Name and Address)

to disclose to 5 \_\_\_\_\_  
(Name and Address of Organization and/or Person Making Disclosure)

Authorize 5 \_\_\_\_\_  
(Name and Address of Organization and/or Person Receiving Information)

to disclose to 4 \_\_\_\_\_  
(Name and Address of Organization and/or Person Receiving Disclosed or Re-disclosed Information)

7 The following information (check the boxes that apply):

<input type="checkbox"/> Medical History, Examination Reports, and medications	<input type="checkbox"/> Prescriptions	<input type="checkbox"/> Reports of Participation and progress and Treatment
<input type="checkbox"/> Operation Reports	<input type="checkbox"/> Consultations	<input type="checkbox"/> Discharge Plans
<input type="checkbox"/> HIV Test Results	<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Treatment or Tests
<input type="checkbox"/> Fitness for Duty Concerns	<input type="checkbox"/> Results of Drug Screens	<input type="checkbox"/> Copies of all Other Reports
<input type="checkbox"/> Alcohol, Drug Abuse Reports	<input type="checkbox"/> Job Performance Functions	<input type="checkbox"/> Mental Health Records, Psychiatric, Social,
<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Hospital Records, Reports, Dates of Hospitalization and Discharge	<input type="checkbox"/> Psychological, and other Allied Health Evaluations
<input type="checkbox"/> Other: _____		

6 Purpose(s) or need(s) for release:

Ongoing diagnosis, treatment planning, social, vocational, fiscal or educational planning  
 Determining the appropriateness of services being provided and coordination of diagnostic evaluation, treatment planning and/or medical, social, vocational and/or psychological service delivery  
 Rehabilitation case management of medical condition as a result of a workers' compensation injury  
 Claims appeal or claims processing  
 For any lawful purpose  
 Other: \_\_\_\_\_

This authorization includes the types of information set forth above generated until the date of signature AND subsequently if generated before: 9 \_\_\_\_\_

I understand that individually identifiable health information ("IIHI") is protected under Federal and/or State confidentiality law. I further acknowledge that the information to be released was fully explained to me and this authorization is given of my own free will. I may withdraw this authorization to disclose IIHI at any time by written revocation except to the extent that the program or person that is to make this disclosure has acted in reliance on it. Upon revocation of this authorization, further release of IIHI authorized by this shall cease immediately. If not previously revoked, this authorization will terminate upon \_\_\_\_\_ year(s) from the date written on this form. A file copy is considered equivalent to the original.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, or a contractor thereof, the released IIHI may no longer be protected by federal privacy regulations. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand that KEPRO will [not] receive financial or in-kind compensation in exchange for using or disclosing the IIHI described above.

<span style="border: 1px solid black; border-radius: 50%; padding: 2px;">8</span> _____ Signature of Patient	<span style="border: 1px solid black; border-radius: 50%; padding: 2px;">8</span> _____ Signature of Parent, Guardian or Authorized Representative	<span style="border: 1px solid black; border-radius: 50%; padding: 2px;">8</span> _____ Witness
<span style="border: 1px solid black; border-radius: 50%; padding: 2px;">8</span> _____ Date	<span style="border: 1px solid black; border-radius: 50%; padding: 2px;">8</span> _____ Date (if required, and relationship)	

Legal Authority:  Parent or Legal Guardian  Next of Kin of Deceased

The person signing this authorization is entitled to a copy.

**TO THE RECIPIENT OF CONFIDENTIAL INFORMATION: PROHIBITION ON REDISCLOSURE.** If the information disclosed to you relates to alcohol and other substance abuse treatment, this information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other substance abuse patient.

tepfile/01ms/riskmg/asthdir.nl 8/25/95; revised 10/30/2014

1 Please enter the member's name, DOB and SSN

2 Please enter the member's legal guardian's name

3 Please enter YOUR AGENCY NAME and address.

4 Please enter YOUR AGENCY NAME and address

5 Please enter KEPRO, 82 Running Hill Rd., Suite 202 South Portland, ME 04106

6 Place a check mark next to the intended purpose of sharing the information between your agency and KEPRO

7 Place a check mark next to the information intended to be shared between your agency and KEPRO

8 Please have the member or legal guardian sign and date the form

9 Please enter the expiration date of the release