**Authorization to Share Information With**

**Primary Care Physician**

**I understand that my records are protected under the applicable state law governing health care information that relates to mental health services, KRS 304.17A-555, and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This Authorization to Share Information will automatically expire one year after the date of your signature.**

**Electronic Records are preferred. Send by Fax to 502-899-5411 or**

**Secure Email at** **office@transformationsllc.net**

**Select one:**

 **\_\_\_I give permission to my Physician and to Transformations to share any applicable information from my Protected Health Information including immunization, treatments, behavioral health treatment plans, recommendations and other health care records.**

**\_\_\_I do not give my Physician and Transformations permission to share my protected health care information.**

**Primary Care Physician Name, Address, Email Address & Fax Number**

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***Patient or Guardian signature please date***

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Date of initial consult \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis or brief description of presenting problem

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Recommendations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Provider/credentials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Faxed or Mailed \_\_\_\_\_\_\_\_\_\_\_\_

Transformations Hope for Today’s Families 4010 Dupont Circle Suite 582 Louisville KY 40207

Phone and Fax: 502-899-5411 Email: office@transformationsllc.net