Authorization for Emergency Contact

Client Information

Client Legal Name\*

Client Birth Date\*

Client Medicaid or Insurance #\*

Statement of Authorization

I authorize Transformations Hope for Today's Families LLC, 4010 Dupont Circle Suite 582, Louisville KY 40207, phone/fax 502-899-5411, secure email office@transformationsllc.net, and its representatives, and the following person and/or organization:

First and Last Name of Authorized Person\*

Relationship to Client\*

Address of Authorized\*

Street Address

Address Line 2

City

State / Province / Region

ZIP / Postal Code

Phone Number of Authorized\*

Email Address of Authorized

To share with one another the information from my Protected Health Healthcare Information, necessary to obtain prevention and treatment.

I understand that the purpose of this authorization is to share information necessary to obtain emergency medical care.

I understand that I may refuse to sign this authorization and that Transformations, LLC and its representatives will not allow my refusal to interfere with the receipt or payment of behavioral health services.

I understand that refusal to complete and sign an authorization for emergency release will, by state regulations, prohibit the client from participating in Telehealth sessions.

I understand that I may revoke this authorization, at any time, in writing to Transformations at the address indicated above, except if Transformations or its representative has taken any action based on prior authorization or obtained my authorization for the purpose of receiving reimbursement from a third party.

This authorization will expire one year from the date of signing, or immediately following the revoking of the authorization.

I understand that pursuant to KRS 304.17A-555-Patient’s Right of Privacy Regarding Mental health or Chemical Dependency-Authorization Disclosure, my Protected Health Information, used and /or shared under this authorization may not be shared by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the re-disclosure.

Explanation of practices and services is available on our website or at your request.

I have read and understand the above information and am legally qualified to authorize the sharing of this protected healthcare information. \*

 Yes

Signature of Client or Legal Guardian\*

Name of Person Signing\*

Relationship to Client\*

Email Address\*

Date of Signature\*