Authorization to Share 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:

Who are you authorizing? (Select One) \*

 Emergency Medical Contact

 Primary Care Physician

 Psychiatrist

 Pediatrician

 Family Member

 School or Educational Institution

 Childcare Provider or Facility

 Foster care Agency

 Foster care Caregiver

 DJJ - Department of Juvenile Justice

 DCBS - Department for Community Based Services

 Other

To share with one another the following items from my Protected Health Information: psychological, psychiatric, clinical, medical and educational evaluations, academic reports, IEP reports, records, treatment plans, progress updates and recommendations both written and verbal.

I understand that the purpose of sharing this information is for the coordination of care.

In educational settings, I understand that the purpose of sharing this information is for the provider to work with and support the educational system, assess the child’s behavioral needs, and provide recommendations and interventions in the academic setting.

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 there is a relationship between mental health and physical health and a collaboration of care with a client’s primary care physician and medical professionals will enable better outcomes.

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.

I understand that pursuant to 45 CFR 46.101(b.2) only data that has been separated from my child’s identifiable information may be used for research and program development purposes, unless written consent by signing an authorization form is provided.

Click here for explanation of practices and services

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\*