## LUKE BUCKMAN, LCSW

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## AUTHORIZATION TO USE AND DISCLOSE INFORMATION

Name of Client		
Other Possible Names	First	Middle
Date of Birth	Phone	
Address		
City/State	Zip	Code
I hereby authorize the Provider to use and	d disclose the information i	ndicated below to:
Name		
Address		
Phone	Fax	
Information may be:   Malled  Revie	ewed Only Picked up b	у:
Information to be used and disclosed (che From and to dates:  ☐ Personal Identifying Information ☐ Assess Plan ☐ Current Treatment Update ☐ Presen Summary ☐ Continuing Care Plan ☐ Progre Payment Information ☐ Other	sment  Diagnosis  Psychosice/Participation in Treatment  se in Treatment  Demograpi	☐ Discharge/ I ranster
I understand that information to be used information, HIV-related information, and mental illness and/or substance abuse and the use and disclosure of information related uses and disclosure of information alcohol/dr □ Mental Health Treatment □ HIV related information (including AIDS	and disclosed may include for information relating to do that by signing this Authorating to (check all that applying abuse)	iagnosis or treatment of orization, I am authorizing
Purpose for the use and disclosure (chec ☐ Changing provider ☐ Second opinion ☐ C☐ Insurance ☐ Workers' Compensation ☐ Se	ontinuing care 🗆 Legal 🗆 Per	sonal

## I understand and agree as follows:

- a. This Authorization will expire 6 months from my last date of service provided by the Provider. I may shorten, extend, or revoke this Authorization at any time by notifying the Provider in writing at 1008 South Broadway, Lexington, Kentucky 40504, which will be effective on the date the notice is received except to the extent action has been taken in reliance upon this Authorization;
- b. If I am receiving treatment related to mental health or substance abuse, I authorize the Provider (i) to use information maintained by Office Ally and Practice Mate, to obtain payment for services rendered and (ii) to use and disclose my information, including but not limited to my protected health information, to obtain payment from such entitles for services rendered and

Authorization will be considered as valid as the original.		
Signature of Client:		
Signature of Parent, Guardian or Responsible Party of a Client who is a Minor:		
: Check here if Authorization not given		
The Provider will not condition treatment or payment on this Authorization. Information disclosed		

c. I have received a copy of this Authorization after I sign it or refuse to sign it. A photocopy of this

pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected by applicable law, rule, or regulation.

## Prohibition on Redisclosure:

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 drug abuse patient.