AUTHORIZATION FOR RELEASE OF INFORMATION

Kentucky Physicians
Health Foundation

Participant Name: _____ Phone Number: _____

Email Address: _____

Release Information To:

Company or Individual: _____

Address: _____

Email Address: _____ Phone Number: _____

1. I, the undersigned Participant, hereby request and authorize Kentucky Physicians Health Foundation, 9000 Wessex Place, Suite 305, Louisville, KY 40222, its employees, agents, and representatives ("KPHF"), to use and release the information described below to the above-named entity.
2. This Authorization for Release of Information ("Authorization") is made at my request.
3. This Authorization applies to information furnished to or produced by KPHF regarding my actual or suspected alcohol or substance abuse or other impairment, including: a copy of any contract or other program arrangement I have or had with KPHF; summaries of information pertaining to my history, diagnosis, and treatment regarding substance use, behavioral health, and mental health; summaries of my progress and compliance with my KPHF contract, monitoring program, or other program arrangement; and, summarized results of my toxicology screening(s).
4. I further authorize KPHF and the above-named entity to communicate with one another, either verbally or in writing regarding any and all information that pertains to my past or present relationship with KPHF.
5. I may revoke this Authorization at any time by submitting my revocation in writing to KPHF.
6. Unless revoked by me in writing, this Authorization will be effective for **thirty (30) days** from the date of its execution.
7. I understand that my revocation of this Authorization: (i) will not apply to any release of documents or information already made in reliance on this Authorization; and, (ii) will not prohibit KPHF's release of any documents or information that is permitted without my authorization or required by law.
8. A photocopy or electronically transmitted or recorded copy or image of this Authorization shall be deemed to have the same legal effect as the original.
9. I acknowledge that I have and will keep a copy of this Authorization for my records.

_____ _____
Signature of Participant: Date:

_____
Printed Name of Participant:

_____ _____
Signature of Witness: Date:

_____
Printed Name of Witness:

Revised: 10/3/2018KMM