AUTHORIZATION FOR RELEASE OF INFORMATON

Client Name:_____ DOB:_____ Case #:_____

Staff Contact (print) :_____ Staff phone. ext.: _____

I hereby authorize **Catholic Charities, Diocese of Covington, 3629 Church Street, Covington, KY 41015 ph: 859.581.8974 fax:859.581.9595**

TO ____ disclose copies of my records to: ____receive copies of my records from: ____ or exchange my medical information with:

Specific Person/Entity:_____Phone# _____Fax#_____

Full Address/City/Sate/Zip:_____

I authorize the following information to be released/obtained: __ Diagnostic Assessment

__Treatment Plan	__Diagnosis	__Attendance	__Psychiatric Eval
__Progress	__Urine Screen	__Progress notes	__Psychiatric Progress
__Complete Record	__Neurological Eval	__ Psychological Test Results	__Current Medications/Medical History

__Other, Specify:_____

This authorization includes but is not limited to records relating to: Diagnoses and/or treatment for alcohol/drug abuse/related conditions, AIDS/HIV test results, HIV/AIDS, AIDS Related Complex ARC, diagnoses and/or treatment, diagnoses and/or treatment relating to other communicable disease and/or sexual abuse.

Records requested for time period of FROM (Date)_____TO Present_____

Initial below:

____This release will **expire in 1 year** unless an earlier date is specified here_____

____**All releases will expire 90 days after services are terminated** unless an earlier date is specified here_____

My refusal to sign this authorization will NOT affect my ability to obtain treatment. I understand that I have the right to shorten or lengthen the authorization period at any time, which will require a new release be written. I understand that I may inspect or copy the information to be used or released and a fee may be applied. I also understand that I have a right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that Catholic Charities, Diocese of Covington has already taken action in reliance on my authorization.

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by Federal Regulations. The 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.

_____ _____

Signature of (Clients/Parent/Guardian/Personal Representative-**Circle One**) Date

_____ _____

Signature of staff, credentials Date

If I revoke this authorization in writing, I may do so by completing the designated section below or by submitting a written statement to my therapist/worker. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal or state health information privacy laws, they may further release the protected health information, and it may no longer be protected by these laws.

Revocation:

I hereby revoke consent: _____ _____

Client/Parent/Guardian/Personal Representative and Date Signature of Person Witnessing Revocation and Date

THE CLIENT MUST BE OFFERED A COPY OF THIS RELEASE ONCE SIGNED.

A fax of this signed document may be accepted in lieu of the original.

Fee Agreement

Catholic Charities is a private, non-profit social service agency that is funded through donations, grants, fees and the United Way.

Fee Agreement

I understand that my fee is $_____ per hour (or service) and that the payment of this fee is expected at the beginning of each session. (For Insurance clients, I understand this is my expected portion of the fee but could change based on insurance reimbursement). I understand that if I fail to pay the assigned fee, services will be terminated unless arrangement for payment is made. I also understand that this fee (or part of this fee) may be applied to telephone services that are therapeutic in nature. Payment arrangement should be discussed with your service provider.

Insurance

Catholic Charities accepts some insurance plans. **I authorize Catholic Charities to release any information necessary to process claims and permit payment directly to Catholic Charities any benefits due for services rendered.** I understand that if complete insurance information is provided that every reasonable effort to collect from my insurance company will be made. I realize that I should contact my insurance company to ensure timely payment. If my insurance company fails to pay or pays only a portion of the bill(s) after 90 days I am responsible for prompt payment of any remaining balance(s). Financial responsibility for the bill(s) remains with me until full payment is made.

Appointment Cancellation Policy

If you must cancel an appointment, we ask that you give your service provider at least 24 hours' notice. You will be charged your ***usual fee*** for missed and late-canceled appointments. Since insurance cannot be billed for missed appointments and co-pays cannot be accepted for missed appointments, there is a $25 charge for our insurance clients for missed and late-canceled appointments. For services that are not charged a fee, there is a $10 charge for missed and late-canceled appointments. Payment of these charges will be expected prior to the beginning of the next session.

Client (person financially responsible):_____ Date:_____

Agency Representative:_____ Date:_____

Catholic Charities
Diocese of Covington

Case Name_____ Case #_____

INITIAL INFORMATION (First Session)

1. Please write a few sentences about the concern that brings you here. (Presenting problem)

2. What do you hope/dream will be different or will change by your coming here? (Goal)

3. What are your resources or strengths that help you toward achieving your hopes or dreams? (Strengths)

4. What is keeping you from attaining your dream or hope for change? (Barriers)

Stress and Life Transitions can affect your physical health. We recommend that everyone have a preventative health care checkup each year.

5a. Have you seen your doctor in the last 12 months? ____Yes ____No

5b. Please rate your overall health, circle one: Excellent Very Good Good Fair Poor

6a. How many times in the past year have you had 4 drinks (women) 5 drinks (men) or more drinks in a day?
Never 1-3 times 4-6 times 6+

6b. How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?
Never 1-3 times 4-6 times 6+

_____ _____
Client signature date Client/Parent signature (If Minor) date

_____
Therapist signature, credentials date

General Consent

I HAVE BEEN GIVEN A COPY OF CATHOLIC CHARITIES' (Provider) "*NOTICE OF PRIVACY PRACTICES*" AND A COPY OF "*CLIENT RIGHTS & RESPONSIBILITIES*".

Please complete the following information:

In case of an emergency I authorize Provider to contact _____ at (_____)_____. My relationship to this contact is _____.

I wish to be contacted by Provider in the following manner for any **necessary** communication. Billing statements are mailed. (Please check all areas that would be an acceptable manner to contact you);

□ Home telephone: (_____) _____-_____

□ Work: (_____) _____-_____

□ Cellular telephone (_____) _____-_____

□ Provider may leave their name and phone number only when they call.

□ Provider may leave a detailed message when they call.

□ Provider may not leave any information.

□ Provider may fax me information: (_____) _____-_____.

□ Provider may email me at the following email address: _____

I understand that the services that I will receive while a client of Catholic Charities (Provider) are contingent upon my signature on this consent document.

Client Printed Name _____

Client Signature_____ Date_____

Name of Authorized Personal Representative (if under 18) _____

Relationship to Client □ Parent □ Legal Guardian □ Other_____

Staff Signature_____ Date _____

Catholic Charities
Diocese of Covington

HOUSING AUTHORIZATION FOR RELEASE OF INFORMATON

Client Name: _____ DOB: _____ Case #: _____

Staff Contact (print): Patti Anderson Staff phone, ext.: (859) 581-8974 ext. 122

I hereby authorize **Catholic Charities, Diocese of Covington, 3629 Church Street, Covington, KY 41015 ph: 859.581.8974 fax:859.581.9595**

To Release or Obtain Information regarding my:

__Mortgage Delinquency __Finances __Pre-Purchase __Rental

__Other Specify: _____

From the following:

__Mortgage Holder/Servicer __Attorney __Credit Bureau __Legal Aide

__Partners (KY Housing, HUD, CCUSA, City of Covington, etc.)

__Other, Specify: _____

Initial below:

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_____ _____

Signature of (Clients/Parent/Guardian/Personal Representative-**Circle One**) Date

_____ _____

Signature of staff, credentials Date

If I revoke this authorization in writing, I may do so by completing the designated section below or by submitting a written statement to my worker. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal or state health information privacy laws, they may further release the protected health information, and it may no longer be protected by these laws.

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I hereby revoke consent: _____ _____

Client/Parent/Guardian/Personal Representative and Date Signature of Person Witnessing Revocation and Date

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