CHFS-305
922 KAR 1:510
(R. 8/2019)

CABINET FOR HEALTH AND FAMILY SERVICES
COMMONWEALTH OF KENTUCKY
PROTECTION AND PERMANENCY
Authorization for Disclosure of Protected Information
PLEASE PRINT LEGIBLY

This form must be completed to authorize the disclosure of protected information.	
I HEREBY AUTHORIZE PROTECTION AND PERMANENCY IN THE DEPARTMENT FOR COMMUNITY BASED SERVICES IN THE CABINET FOR HEALTH AND FAMILY SERVICES TO DISCLOSE AND USE THE SPECIFIED INFORMATION BELOW.	
Individual Requesting Records: Name (Print)	Address
City, State, Zip Code	
Telephone Number (Home)	(Work)
Please Send Records To: Name (Print)	Address
City, State, Zip Code	
Telephone Number (Home)	(Work)
The name of the individual whose information you authorize the disclosure of:	
Social Security Number	Date of Birth
Case Record # (if known)	County where case record is maintained
I request to inspect the following document(s):	
The purpose for disclosure is: **(Note: Must complete, Do Not Leave Blank)**	
Please attach a copy of photo ID for verification	
The specific protected information you authorized the disclosure of: ☐ Medical History ☐ Immunizations ☐ Treatment Information ☐ Developmental Information ☐ Benefits Eligibility Records ☐ Payment Records ☐ Medicaid Claim Information ☐ Child Protective Services Information (Provide Court Custody Order, Court Order or Birth Certificate) ☐ Adult Protective Services Information (Provide Court Order or POA) ☐ Other_____	

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Please read carefully

- Complete this form and submit it within ten (10) days to the **Cabinet for Health and Family Services, Department for Community Based Services, Records Management Section, 275 East Main St., Section 3E-G, Frankfort, Kentucky, 40621.**
- I understand this authorization will expire in ninety (90) days.
- I understand I have the right to revoke this authorization at any time, however I must do so **in writing**. I further understand that actions already taken based on this authorization prior to revocation will **not** be affected.
- I understand I have the right to a copy of this authorization.
- I understand that authorizing the use/disclosure of public information is voluntary. I need not sign this authorization in order to assure service. I may request to inspect or receive a copy of information to be used or disclosed, as provided in 45 CFR 164.524. I further understand that any disclosure carries with it the potential for an unauthorized disclosure and the information may not be covered by federal confidentiality rules.
- I understand that information may be subject to re-disclosure and no longer protected.
- The following statement applies to any alcohol and/or drug abuse treatment information disclosed. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations, 42 CFR Part 2, prohibit you from making further disclosures without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure is **not** sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my information.

Signature _____ Date_____

THIS FORM MUST BE COMPLETE

Records Requests Fee: The charge is ten cents ($0.10) per page after twenty (20) pages, plus postage. Please do not send money with this request. This office will notify you of the amount due once the records are available.