EnSite: Counseling Program

Client Information

Last Name	First	Middle	☐Mr ☐Mrs.	☐ Miss ☐ Ms.
Is this your legal name? ☐Yes ☐ No	If not, what is your legal name? (Former Name)			
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed		Birth date / /	Age	Sex: ☐M ☐F
Street Address:				
P.O. Box	City	State	Zip Code	
Social Security No.	Home Phone No. ( )	May we leave a message? ☐ Yes ☐ No		
Cell Phone No. ( )	May we leave a message? ☐ Yes ☐ No	Were you referred? ☐Yes ☐ No	If yes, who referred you?	
Occupation				
Employer or School name			Employer Phone No. ( )	
Have you previously been seen at EnSite? ☐Yes ☐No	If yes, When?			
Is this appointment for a DUI? ☐Yes ☐No	If yes, how many?			
Please list others in your household:				

IN CASE OF EMERGENCY

Name of a local friend or relative (not living at same address):	Relationship:	Phone No.: ( )

The above information is true to the best of my knowledge:

Signature: _____

EnSite: Counseling Program

Health Status Questionnaire

Name of Client _____ Age _____ Gender _____

Height _____ Weight _____

Hw would you describe your overall health? (Please circle one) Excellent Good Fair Poor

Medical Conditions or Complications:
Do you have a history or currently suffer with any of the following conditions or complications?

A. Tuberculosis (TB)	Yes___	No___
B. Hepatitis	Yes___	No___
C. Cirrhosis	Yes___	No___
D. Pancreatitis	Yes___	No___
E. HIV/AIDS	Yes___	No___
F. Heart Disease	Yes___	No___
G. Circulatory Problems	Yes___	No___
H. Hypertension	Yes___	No___
I. Diabetes	Yes___	No___
J. Seizures	Yes___	No___

Are you currently experiencing any of the following physical symptoms?

A. Insomnia	Yes___	No___
B. Tiredness	Yes___	No___
C. Weight gain or loss	Yes___	No___
D. Pain	Yes___	No___
E. Headaches	Yes___	No___
F. Dizziness or Lightheadedness	Yes___	No___
G. Numbness or tingling	Yes___	No___
H. Vomiting	Yes___	No___
I. Rapid heart beat	Yes___	No___
J. Dry mouth	Yes___	No___
K. Excessive sleep	Yes___	No___
L. Loss of memory	Yes___	No___
M. Eating problems	Yes___	No___
N. Constipation	Yes___	No___
O. Other	_____	

EnSite: Counseling Program

Health **How often have you experienced the following physical, mental, or emotional states in the past year:**	**Never**	**Rarely**	**Occasional**	**Regularly**	**Constantly**
Presence of physical pain (neck/back, arms, legs etc.)	1	2	3	4	5
Feelings fo tension, stiffnes, lack of flexibility	1	2	3	4	5
Incidence of fatique or low energy	1	2	3	4	5
Incidence of headaches	1	2	3	4	5
Incidence of allergies, exczema or skin rash	1	2	3	4	5
Incidence of accident or near accidents, falling, or tripping	1	2	3	4	5
Stress related pain	1	2	3	4	5
Difficulty with sleep (falling asleep, staying asleep)	1	2	3	4	5
Experience depression or lack of interest	1	2	3	4	5
Difficulty concentrating, indecisiveness, restlessness	1	2	3	4	5
Difficulty adjusting to changes in your life	1	2	3	4	5

Stress	**None**	**Little**	**Some**	**A Lot**	**Extreme**
How much stess does your general state of being cause you?	1	2	3	4	5
How much stress do your family, loved ones,	1	2	3	4	5
significant others and friends cause you?	1	2	3	4	5
How much stress does your job cause you?	1	2	3	4	5
How much stress does unemployment or inability	1	2	3	4	5
to work cause you	1	2	3	4	5
How much stress do legal issues cause you?	1	2	3	4	5
How often do you experience relaxation, ease and	1	2	3	4	5
feelings of well-being?					

Have you been hospitalized during the past year? Yes____ No____

If you answered "yes" then please explain: _____

EnSite: Counseling Program

Do you see a doctor or other primary health care professional?

If so, what is the name of that person(s)

Are you prescribed any medication(s)

If you answered yes, please fill in the following:

Medication: Daily Doseage:

Taken For: Prescribed By:

How long have you been taking this medication?

Have you ever abused this medication?

Taken For: Prescribed By:

How long have you been taking this medication?

Have you ever abused this medication?

Taken For: Prescribed By:

How long have you been taking this medication?

Have you ever abused this medication?

Do you currently, or have you in the past been under the care of a psychiatrist?

If you answered "yes" then please explain:

Do you currently, or in the past, see a substance abuse of mental health counselor or therapist?

If you answered "yes" then please explain:

EnSite: Counseling Program

Life History Questionnaire
(All files are held in strict confidence)

Referred By: Date: Court Case:

First Name: MI: Last Name: Maiden:

Highest Grade Level Achieved:
Elementary Middle High College

Currently Employed:

Other Info:

Please read the following questions and mark those to which you would respond "yes."

- ☐ Have you previously been involved in counseling?
- ☐ Do you currently use alcohol or other non-prescription drugs?
- ☐ Is there a history of mental health problems in your family?
- ☐ Have you ever been physically abused?
- ☐ Have you ever been emotionally abused?
- ☐ Are your concerns interfering with your academic performance?
- ☐ Have you ever attempted suicide?
- ☐ Have you ever been hospitalized for mental health reasons?
- ☐ Is there a history of alcohol or drug problems in your family?
- ☐ Have you ever been in legal trouble?
- ☐ Have you ever been sexually abused or assaulted?
- ☐ Are you currently taking any prescription medication?
- ☐ Are your concerns interfering with your ability to stay in school?

Please describe the concerns that you would like to discuss:

How long has this problem persisted?

Under what condition do your problems get worse? Better?

If in a relationship/married/cohabitating, please describe the relationship.

Life History Questionnaire
Continued, Page 2

Please use the following scale to answer the next three questions:	1 Not at all	2 Mildly	3 Moderately	4 Highly
1. How serious do you consider your present concern(s)?	☐	☐	☐	☐
2. How motivated are you to resolve your concern(s)?	☐	☐	☐	☐
3. How optimistic are you that your concern(s) can be resolved?	☐	☐	☐	☐

Family History		
	Mother's Age:	If deceased, how old were you when she died?
	Father's Age:	If deceased, how old were you when he died?
	If your parents are seperated, how old were you then?	
	Number of brother(s):	Age(s):
	Number of sister(s):	Age(s):

If you were adopted or raised with parents other than your natural parents please explain:

Briefly describe your mother's personality:	Briefly describe your father's personality:

Briefly describe your stepparent(s) personality:

Briefly describe your past and current relationship with your:

Mother:	Father:
Stepmother:	Stepfather:

Religious Affiliation:

☐ Jewish
☐ Catholic
☐ Christian:
☐ None, but I believe in God
☐ Atheist or agnostic
☐ Other:

Is there a history of abuse or are you currently at risk for abuse?

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Life History Questionnaire
Continued, Page 3

Please mark all of the following that apply

Feelings

- ☐ Helpless
- ☐ Depressed
- ☐ Shameful
- ☐ Angry
- ☐ Guilty
- ☐ Hopeless
- ☐ Lonely
- ☐ Sad
- ☐ Stressed
- ☐ Unhappy
- ☐ Other
- ☐ Anxious
- ☐ Out of Control
- ☐ Afraid
- ☐ Numb
- ☐ Relaxed
- ☐ Happy
- ☐ Excited
- ☐ Hopeful
- ☐ Inferiority Feeling
- ☐ Mood Shifts

Thoughts

- ☐ confused
- ☐ Unintelligent
- ☐ Worthless
- ☐ Unmotivated
- ☐ Unattractive
- ☐ Unlovable
- ☐ Confident
- ☐ Worthwhile
- ☐ Homicidal
- ☐ Other
- ☐ Racing
- ☐ Obsesive
- ☐ Distracted
- ☐ Disorganized
- ☐ Paranoid
- ☐ Suicidal
- ☐ Sensitive
- ☐ Honest

Symptoms/Behaviors

- ☐ Eating Less
- ☐ Procrastinating
- ☐ Attempting Suicide
- ☐ Poor Concentration
- ☐ Crying
- ☐ Withdrawing Socially
- ☐ Skipping Classes
- ☐ Binge Drinking
- ☐ Injuring Self
- ☐ Compulsivity
- ☐ Career/Major Choice
- ☐ Acting Out Sexually
- ☐ Acting Aggressively
- ☐ Disorganization
- ☐ Impulsivity
- ☐ Recklessness
- ☐ Ittitability
- ☐ Passivity
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Being Good to Yourself
- ☐ Sexual Problems
- ☐ Socializing
- ☐ Marital Relationships
- ☐ Parent/Child Conflicts
- ☐ Lack of Ambition/Goals
- ☐ Poor Peer Relationships
- ☐ Night Mares
- ☐ Worries About Body Image
- ☐ Spiritual Problems
- ☐ Dating Concerns
- ☐ Finances
- ☐ Other

Physical Symptoms

- ☐ Insomnia
- ☐ Tired
- ☐ Weight Gain or Loss
- ☐ Pain
- ☐ Headaches
- ☐ Tightness in Chest
- ☐ Dizziness or Light-headedness
- ☐ Numbness or Tingling
- ☐ Vomiting
- ☐ Rapid Heart Beat
- ☐ Dry Mouth
- ☐ Excessive Sleep
- ☐ Loss Of Memory
- ☐ Eating Problems
- ☐ Other:

Please describe any family history of substance abuse or mental illness:

Please describe your current and past use of alcohol and/or drugs:

Effective Date: _____

Notice of privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

This notice describes how health information about you (as a client at En Site) may be used and disclosed and how you can get access to your individually identifiable health information.

A. Our commitment to your privacy:

Effective Date:_____

Notice of privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

This notice describes how health information about you (as a client at En Site) may be used and disclosed and how you can get access to your individually identifiable health information.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practices concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all time, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact EnSite 270-443-1201

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. **Treatment**: Our practice may use your PHI to treat you.
2. **Payment**: Our practice may use and disclose your PHI in order to bill and collect payment for the services and items your may receive from us.
3. **Health care operations**: Our practice may use and disclose your PHI to operate our business.
4. **Optional Appointment reminders**: Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. **Optional Treatment options**: Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. **Disclosures required by law**: Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

D. Use and disclosure of your PHI in certain circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public health risks**: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths,
    - Reporting child abuse or neglect,
    - Preventing or controlling disease, injury, or disability,
    - Notifying a person regarding potential exposure to a communicable disease,
    - Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
    - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
2. **Health oversight activities**: Our practice may disclose your PHI to a health oversight agency for activities authorized by law.
3. **Lawsuits and similar proceedings**: Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHII in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law enforcement**: We may release PHI if asked to do so by law enforcement official:
    - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
    - Concerning a death we believe has resulted from criminal conduct.
    - Regarding criminal conduct at our offices.
    - In response to a warrant, summons, court order, subpoena, or similar legal process.
    - To identify/locate a suspect, material witness, fugitive, or missing person.
    - In an emergency, to report a crime (including the location or victims(s) of the crime, or the description, identity or location of the perpetrator).
5. **Serious threats to health or safety**: Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. **Military:** Our practice may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

7. **National Security:** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential communications:** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.

2. **Requesting restrictions:** You have the right to request a restriction in our use or disclosure or your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to EnSite. Your request must describe in a clear concise fashion:

- The information you wish restricted.
- Whether you are requesting to limit our practice's use, disclosure or both.
- To whom you want the limits to apply.

3. **Inspection and copies:** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing record, but not including psychotherapy notes. You must submit your request in writing to EnSite in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request and amendment for as long as the information is kept by or for our practice. To request and amendment, your request must be made in writing and submitted to EnSite. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit you request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Right to a paper copy of this notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact EnSite.

6. **Right to file a complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact EnSite. All complaints may be submitted in writing. **You will not be penalized for filing a complaint.**

7. **Right to provide and authorization for other uses and disclosures:** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note: we are required to retain records of your care.*

I hereby acknowledge that I have received the opportunity to ask questions concerning this Notice of Privacy Practices:

_____ _____

Signature or Patient or Representative Date

_____ _____

Witness Date

EnSite: Counseling Program

CLIENT RIGHTS AND RESPONSIBILITIES STATEMENT

It is the policy of this center to provide services to individuals in an effective and efficient manner. Services will be directed toward the individual's health and habilitation and will be provided in the least restrictive setting possible.

An individual receiving services has the following rights:

1. To receive a Notice of Privacy Practices.
2. To not be unlawfully discriminated against in determining eligibility for services.
3. To be treated with consideration and respect for human dignity.
4. To receive quality treatment regardless or race, gender, religion, ethnic background, disability, age, or ability to pay.
5. To give informed consent to treatment and be involved in planning your treatment.
6. To receive individualized treatment, be informed about your treatment process, and review your treatment plan.
7. To obtain one free copy of your records upon written request except as limited by law.
8. To refuse treatment to the extent permitted by law and to be informed about the possible consequences of your actions.
9. To be involved in your discharge and aftercare planning.
10. To be provided confidentiality and protection from any unauthorized disclosure regarding your treatment.
11. To examine and receive and explanation of fees for services.
12. To submit grievances, opinions, and recommendations about the program or the services received through the internal grievance procedure of this center, the Center Ombudsman, if any, or the Cabinet for Health Services Ombudsman.

As an individual receiving service you have the following responsibilities:

1. To arrive on time, attend, and participate in all treatment sessions.
2. To cancel any sessions you are unable to attend.
3. To make up any session you missed.
4. To be alcohol and drug free for all sessions you attend with the understanding that if you arrive under the influence of alcohol and/or drugs appropriate steps will be taken by the center staff to ensure your safety and the safety of others.
5. To refrain from wearing any clothing with drugs or alcohol advertisements.
6. To actively work on your treatment plan goals.
7. To pay for all services with the understanding that if you fail to pay for services received your completed paperwork will not be forwarded to the appropriate agencies and non-payment may result in a report of non-compliance with the court.
8. To protect the confidentiality of all participants in the program.
9. To follow through with all your treatment recommendations.

Client Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

EnSite: Counseling Program

Education/Treatment Agreement

Client Name: _____

Client ID/SS Number: _____

Agency Name: **EnSite, LLC**

You have selected the above agency/center to provide services at the level of care identified by your assessment. The following provides you with a schedule of times and fees for that service.

_____ Substance Abuse Assesssment and Psychosocial
Fee for this service: $85.00

_____ Group Outpatient Substance Abuse Treatment
Fee for this service: $20 weekly

_____ Individual Outpatient Substance Abuse Treatment
Fee for this service: $50.00

_____ DUI Assessment
Fee for this service: $50.00

_____ DUI 20-hour PRI Program
Fee for this service: $215 (Includes book)

_____ Anger Management/Domestic Violence Assessment
Fee for this service: $50.00

_____ Group Anger Management/Domestic Violence
Fee for this service: $20 weekly

_____ Individual Anger management/Domestic Violence
Fee for this service: $40

_____ Marijuana Education Class
Fee for this service: $70.00

I fully understand the schedule of services and fees required for my participation in the identified program. I agree to pay all fees in full and maintain regular attendance until the completeion of my program. I understand that failure to complete the program or pay the fees assigned will result in a report of non-compliance being sent to the court by this center and may result in a bench warrant being issued by the court.

Signature of Client: _____ Date: _____

Signature of Clinician: _____ Date: _____

EnSite: Counseling Program

Name of Client: Date:

Client ID No.:

Freedom of Choice Form: My signature on this form indicates that I understand that I have the right to choose the service provider of my choice whether or not I have been assessed at EnSite, LLC. I further understand that I have the right to contact other providers prior to selection of my provider so that I may determine the best provider to service my needs. I also understand that I may at any time choose another provider for this service by notifying my current provider.

Confidentiality Agreement: My signature on this form indicates that I am fully aware that I am prohibited from discussion of treatment and personal issues of others that I may accompany in treatment groups or education classes at this facility. My signature on this form also indicates that I will not use any type of recording device to record individuals in the group or education settings. Further, I will not disclose the names or positions of individuals I see at the facility who may or may not accompany me in group or education class. My signature is indication that failure to abide by this agreement shall be grounds to be found "non-compliant" in treatment or education and will be reported to the apporpriate authorities.

Random Screen Consent: The undersigned consents that EnSite, LLC has the right to ask for and conduct random drug/alcohol screenings at my expense.

a. As part of my treatment plan.
b. If I am suspected of being under the influence of any mind or mood altering substances while at the center.

I understand that I may revoke this consent at any time, howeve, if I do revoke my consent, EnSite, has the right to suspend services to me. I further understand that any revocation of this consent must be in writing.

Acceptance of Assessment: I confirm that I have participated in and received the results of my DV or AM assessment and I have been identified as needing the following level of care:

- ☐ 20- Hour Education
- ☐ Intensive Outpatient Treatment
- ☐ Detoxification
- ☐ Outpatient Treatment
- ☐ Residential/Inpatient Treatment

I acknowledge I have been given and HIV/AIDS awareness pamplet

Signature: Date:

Witness: Date:

EnSite: Substance Abuse Counseling
Authorization for Release of Clinical/Treatment Information

Client Name: _____ Date of Birth:_____

Dates of Treatment/Assessment (if known) _____ Social Security #_____

The undersigned hereby authorizes the release of information from the medical record of the above named individual. This information may be released by mail, fax, telephone, or in person

From: Division of Behavioral Health
100 Fair Oaks Ln 4E-D
Frankfort, KY 40601
Fax: 502-564-9335

To: EnSite LLC
611 Broadway
Paducah, Kentucky 42001
Phone 270-443-1201

From: EnSite LLC
611 Broadway
Paducah, Kentucky, 42001
Phone 270-443-1201

To: Division of Behavioral Health
100 Fair Oaks Ln 4E-D
Frankfort, KY 40601
Fax: 502-564-9335

The specific information to be released: (I understand the information released may include psychiatric, psychological, clinical treatment or assessment and drug and alcohol information).

___Assessment and/or Discharge Summary
___History of Physical Exam
___Consults
___Entire Medical Record
___Correspondence
___Other (be specific) _____

___ Physician Notes
___TB Skin Test
___Lab___

Purpose of Release:
___Insurance Claims
___Placement
___Notification of Appointments
___Other: DUI Compliance

___Aftercare
___Facilitation of Treatment
___Legal Purposes

I understand that this authorization for release is subject to revocation at any time in the form of written notification from me except to the extent that action has been taken in reliance thereof. The release will expire, unless otherwise specified, in 1 year after the date it is signed.

Client Signature_____ Date_____

Signature of Parent/Legal Guardian_____ Date_____

Signature of Witness _____ Date_____

EnSite: Substance Abuse Counseling
Authorization for Release of Clinical/Treatment Information

Client Name: _____ Date of Birth:_____

Dates of Treatment/Assessment (if known) _____ Social Security #_____

The undersigned hereby authorizes the release of information from the medical record of the above named individual. This information may be released by mail, fax, telephone, or in person.

From: Department of Transportation
Drivers License Hearing Office
Binford Building
224 N. 8th St., Suite C
Paducah, KY 42001

To: EnSite LLC
611 Broadway
Paducah, Kentucky 42001
Phone 270-443-1201

From: EnSite LLC
611 Broadway
Paducah, Kentucky, 42001
Phone 270-443-1201

To: Department of Transportation
Drivers License Hearing Office
Binford Building
224 N. 8th St., Suite C
Paducah, KY 42001

The specific information to be released: (I understand the information released may include psychiatric, psychological, clinical treatment or assessment and drug and alcohol information).

___Assessment and/or Discharge Summary
___History of Physical Exam
___Consults
___Entire Medical Record
___Correspondence
___Other (be specific) _____
___ Physician Notes
___TB Skin Test
___Lab___

Purpose of Release:
___Insurance Claims
___Placement
___Notification of Appointments
___Other: DUI Compliance
___Aftercare
___Facilitation of Treatment
___Legal Purposes

I understand that this authorization for release is subject to revocation at any time in the form of written notification from me except to the extent that action has been taken in reliance thereof. The release will expire, unless otherwise specified, in 1 year after the date it is signed.

Client Signature_____ Date_____

Signature of Parent/Legal Guardian_____ Date_____

Signature of Witness _____ Date_____

EnSite: Substance Abuse Counseling
Authorization for Release of Clinical/Treatment Information

Client Name: _____ Date of Birth:_____

Dates of Treatment/Assessment (if known) _____ Social Security #_____

The undersigned hereby authorizes the release of information from the medical record of the above named individual. This information may be released by mail, fax, telephone, or in person.

From: Marshall County Circuit Court Clerk
80 Judicial Dr., Unit 101
Benton, KY 42025

To: EnSite LLC
611 Broadway
Paducah, Kentucky 42001
Phone 270-443-1201

From: EnSite LLC
611 Broadway
Paducah, Kentucky, 42001
Phone 270-443-1201

To: Marshall County Circuit Court Clerk
80 Judicial Dr., Unit 101
Benton, KY 42025

The specific information to be released: (I understand the information released may include psychiatric, psychological, clinical treatment or assessment and drug and alcohol information).

___Assessment and/or Discharge Summary
___History of Physical Exam
___Consults
___Entire Medical Record
___Correspondence
___Other (be specific) _____

___ Physician Notes
___TB Skin Test
___Lab___

Purpose of Release:
___Insurance Claims
___Placement
___Notification of Appointments
___Other: DUI Compliance

___Aftercare
___Facilitation of Treatment
___Legal Purposes

I understand that this authorization for release is subject to revocation at any time in the form of written notification from me except to the extent that action has been taken in reliance thereof. The release will expire, unless otherwise specified, in 1 year after the date it is signed.

Client Signature_____ Date_____

Signature of Parent/Legal Guardian_____ Date_____

Signature of Witness _____ Date_____