

**KENTUCKY OPIATE REPLACEMENT TREATMENT OUTCOME  
STUDY TRANSFER RECORD REQUEST AND AUTHORIZATION**

FAX TRANSMISSION COVER PAGE  
**CONFIDENTIAL INFORMATION**

To: Jeb Messer

Fax: 859-257-9070



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**INSTRUCTIONS:**

Complete the following information in order to process a transfer of a KORTOS intake interview record between OTP sites. By signing and submitting this form to UK CDAR, you agree HIPAA authorization forms which protect the transfer of client information have been completed between the transferring agencies.

Fax the 2-page completed form to the name and fax number listed above at the University of Kentucky Center on Drug & Alcohol Research.

Transfers will be completed within 2 business days of your request.

**Client Name:** \_\_\_\_\_  
**Client SSN:** \_\_\_\_\_  
**Client DOB:** \_\_\_\_\_

**1. Select the OTP from which the client record should be removed:**

- Behavioral Health Group (BHG) – Lexington
- Bluegrass – Narcotics Addiction Program
- Center for Behavioral Health (CBH) – Frankfort
- Center for Behavioral Health (CBH) – Louisville
- Corbin Professional Associates
- Daviess Treatment Services
- Elizabethtown Center for Behavioral Health
- MORE Center
- NKY Med Clinic
- Paducah Professional Associates
- Paintsville Treatment Center
- Perry Co. Treatment Center
- Pikeville Treatment Center
- Ultimate Treatment Center
- Western KY Medical

**2. Select the new OTP to which the client record should be transferred:**

- Behavioral Health Group (BHG) – Lexington
- Bluegrass – Narcotics Addiction Program
- Center for Behavioral Health (CBH) – Frankfort
- Center for Behavioral Health (CBH) – Louisville
- Corbin Professional Associates
- Daviess Treatment Services
- Elizabethtown Center for Behavioral Health
- MORE Center
- NKY Med Clinic
- Paducah Professional Associates
- Paintsville Treatment Center
- Perry Co. Treatment Center
- Pikeville Treatment Center
- Ultimate Treatment Center
- Western KY Medical

**Clinician/staff making request:** \_\_\_\_\_  
**Signature of clinician/staff**  
**making request:** \_\_\_\_\_  
**Phone number of clinician/staff:** \_\_\_\_\_

