

**DEPARTMENT OF CORRECTIONS
INMATE GRIEVANCE INFORMATION FORM**

NAME OF INSTITUTION

DATE FILED

_____ GRIEVANT'S NAME	_____ GRIEVANCE NUMBER
_____ GRIEVANT'S NUMBER	_____ UNIT/HOUSING ASSIGNMENT

SUBJECT MATTER OF GRIEVANCES (Circle One)

DUE DATES

1. Department Regulations
2. Canteen
3. Conflict with Staff
4. Disciplinary Procedures
5. Food
6. Furloughs
7. Inmate Accounts
8. Housing Assignments
9. Grievance Mechanism
10. Institutional Physical Conditions
11. Institutional Regulations
12. Job Assignments
13. Legal Services
14. Mail
15. Medical/Dental/Mental Health Services
 - a. Access to Health Care Services
 - b. Quality of Health Care
 - c. Unfair or Discriminatory Treatment
 - d. Safety or Sanitation
16. Personal Property
17. Permission to Marry
18. Recreation
19. Religious Services
20. Telephone Calls
21. Transfers
22. Treatment Program Assignments
23. Trips away from the facility
24. Visiting

Informal Resolution

Grievance Committee

Warden/Administrative Review

Notes/ETC.

**DEPARTMENT OF CORRECTIONS
INMATE GRIEVANCE FORM**

NAME _____
INSTITUTIONAL NUMBER _____
UNIT/HOUSING ASSIGNMENT _____

INSTITUTION _____
GRIEVANCE NUMBER _____
DATE RECEIVED _____

BRIEF STATEMENT OF THE PROBLEM

ACTION REQUESTED

GRIEVANT'S SIGNATURE

DATE

GRIEVANCE AIDE'S SIGNATURE / DATE

INFORMAL RESOLUTION STAGE

STAFF SIGNATURE

DATE

GRIEVANCE AIDE'S SIGNATURE / DATE

I am _____ or am not _____ satisfied with this informal resolution to my grievance. (You have 5 working days to forward this form to the Grievance Coordinator to request a hearing.)

GRIEVANT'S SIGNATURE

DATE

GRIEVANCE COMMITTEE

FINDINGS AND RECOMMENDATIONS

DATE _____

I AM SATISFIED WITH THE RECOMMENDATION
OF THE GRIEVANCE COMMITTEE

COMMITTEE MEMBERS:

I WISH TO APPEAL THIS RECOMMENDATION TO
THE WARDEN. (You have 3 working days to
forward this form to the Warden.)

GRIEVANT'S SIGNATURE / DATE

CHAIRPERSON

WARDEN'S REVIEW

REVIEW AND DECISION

DATE OF DECISION _____

I AM SATISFIED WITH THIS DECISION.

I WISH TO APPEAL THIS DECISION TO THE COMMISSIONER.
(You have 3 working days to forward this form to the Grievance Coordinator for the
Ombudsman.)

GRIEVANT'S SIGNATURE / DATE

WARDEN'S SIGNATURE



Commonwealth of Kentucky
Department of Corrections – Health Care Grievance Process
Authorization for Release of Patient Information

The undersigned patient authorizes as indicated below the disclosure of the patient's health information:

Name of Patient Inmate Number

All dates
Date(s) of Treatment to be Released

Records and information to be released from:

Department of Corrections and/or
Eastern Kentucky Correctional Complex

Records and information to be released to:

Any Corrections staff, health care provider, or other individual who is involved in the grievance process for the handling of patient's health care grievance including review by an outside health care professional (if used in the grievance process)

Grievance aides are to be excluded from this authorization if box is checked.

Purpose of Disclosure:

Inmate Grievance Process

Information to be disclosed includes:

- Admission Records, Discharge Instructions, Radiology, Laboratory, Medication Records, History and Physical, Progress Notes, Physical Therapy Notes, Dental Records, Optometry Records, Physician Orders/Prescriptions, Medical Records from Outside Providers, Mental Health Records, Complete Medical Records, Other (Specify)

I understand that the health records may contain information relating to testing, diagnosis, and/or treatment of hepatitis, HIV/AIDS, sexually transmitted diseases, sickle cell disease, and drug and/or alcohol abuse. I authorize the release of these records, if they are located in my health records, unless I have specifically marked out that type of record from this paragraph.

I understand that the health records may contain information that may relate to mental health, but are also medical in nature including but not limited to medication prescriptions and monitoring, mental status, functional status, and symptoms. I authorize the release of these records. I understand that this authorization does not include the separate mental health section of my medical record, unless it is marked specifically above.

REVOCATION AND TIME LIMITATION: I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year from the date of signature.

REDISCLASURE: The grievance process is confidential and disclosure of information gathered in the process is prohibited from redisclosure outside of the grievance process without an authorization from the patient/inmate. Records pertaining to drug and/or alcohol abuse treatment are prohibited from redisclosure pursuant to 42 C.F.R. Part 2 unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I have read or been informed of the contents of this authorization and all areas were properly completed prior to my signature and I am aware that this form is not required as a condition for treatment. The facility, its employees, and agents are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature (Patient or Legal Representative and Title)

Date

Signature of Witness (if Patient signs with mark)

Date