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Attachment I
CPP 14.6

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)

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

DUE DATES

_____
Informal Resolution

_____
Grievance Committee

_____
Warden/Administrative Review

Notes/ETC.

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Attachment II
CPP 14.6

DEPARTMENT OF CORRECTIONS
INMATE GRIEVANCE FORM

NAME _____ INSTITUTION _____
INSTITUTIONAL NUMBER _____ GRIEVANCE NUMBER _____
UNIT/HOUSING ASSIGNMENT _____ 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

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Attachment III General
CPP 14.6

GRIEVANCE COMMITTEE

FINDINGS AND RECOMMENDATIONS

DATE _____

( ) I AM SATISFIED WITH THE RECOMMENDATION OF THE GRIEVANCE COMMITTEE

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

COMMITTEE MEMBERS:

_____

_____

_____

_____

_____
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.)

_____
GRIEVANTS SIGNATURE / DATE

_____
WARDEN'S SIGNATURE

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Attachment III Health Care
CPP 14.6

HEALTH CARE GRIEVANCE COMMITTEE

FINDINGS AND RECOMMENDATIONS DATE _____

( ) I AM SATISFIED WITH THE RECOMMENDATION OF THE GRIEVANCE COMMITTEE

( ) I WISH TO APPEAL THIS RECOMMENDATION FOR ADMINISTRATIVE REVIEW. (You have 3 working days to forward this form to the Grievance Coordinator.)

_____
GRIEVANT'S SIGNATURE / DATE

ADMINISTRATIVE REVIEW

REVIEW AND DECISION DATE OF DECISION _____

_____
MEDICAL DIRECTOR

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Attachment IV
CPP 14.6

DEPARTMENT OF CORRECTIONS
GRIEVANCE APPEAL FORM

Please complete this form and attach it to your grievance. Explain why you are appealing this grievance to the Warden / Commissioner / Health Care Administrative Review (circle appropriate one).

GRIEVANT'S NAME _____	GRIEVANCE NUMBER _____
GRIEVANT'S NUMBER _____	INSTITUTION _____
	DATE APPEAL FILED _____

_____

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_____ _____

GRIEVANT'S SIGNATURE DATE

Not Filed with LRC – Attachment V

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.

REDISCLOSURE: 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 _____