AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Consumer Last Name: First Name: MI: Date of Birth:

Consumer Address: City, State: Zip:

I authorize Mental Health America of South Central Kansas, 555 N Woodlawn Ste 3105, Wichita, KS 67208 to release / obtain information to / from the following individual / organization:

TO / FROM – INDIVIDUAL / ORGANIZATION:

Name:

Address:

City, State, Zip: Phone:

Fax Number Email Address

RELEASE the following written information:
(Please initial each applicable item)

- ☐ Admission Evaluation Report
- ☐ Diagnosis Only
- ☐ Treatment Plan(s)
- ☐ Psychiatric Consultation Report
- ☐ Psychological Evaluation Report
- ☐ Discharge Summary
- ☐ Progress Review(s)
- ☐ Alcohol and Drug Treatment information

(* See Next Page.)

- ☐ Hospitalization Screening
- ☐ Progress Notes: FROM: TO:
- ☐ Medical Reports:
- ☐ Other:
- ☐ Other:
- ☐ Other:

OBTAIN the following written information:
(Please initial each applicable item)

- ☐ Admission Evaluation Report
- ☐ Diagnosis Only
- ☐ Treatment Plan(s)
- ☐ Psychiatric Consultation Report
- ☐ Psychological Evaluation Report
- ☐ Discharge Summary
- ☐ Progress Review(s)
- ☐ Alcohol and Drug Treatment Information
- ☐ Hospitalization Screening
- ☐ Progress Notes: FROM: TO:
- ☐ Medical Reports:
- ☐ Legal Reports:
- ☐ Education Reports:
- ☐ Other:
- ☐ Other:

VERBAL COMMUNICATION (Please initial if applicable)
☐ I authorize verbal communication with the individual or organization listed above in order to coordinate treatment, allow discussion of treatment progress, and discuss relevant concerns or issues regarding the above–named client's treatment.

RESTRICTIONS – The information indicated will be disclosed unless there are specific restrictions noted here:

THIS DOCUMENT IS NOT VALID UNLESS THE INFORMATION IS COMPLETE ON REVERSE SIDE

THE PURPOSE OR NEED FOR THE DISCLOSURE (Initial all that apply)

☐ Evaluation / Treatment Planning ☐ Case Coordination ☐ Legal Proceedings

☐ School Placement or Assessment ☐ Other

- I understand that under state and federal confidentiality provisions only the information specified can be released to the specified person or agency. (CFR-42, part 2 , KAR 30-60-47(b)(5), AAPS guidelines, Chapter 7)
- I also understand that the MHA cannot ensure that the recipient will maintain confidentiality of this information I have authorized to be released.
- I also understand that this authorization will be honored unless revoked verbally or in writing. Revocation may be made at any time except to the extent that action has already been taken. To revoke an authorization, I need to notify MHA. (KAR 30-60-47(b)(7), AAPS Standards for Licensure/Certification, Chapter 7,1.a.(7), and CFR-42, part 2)
- I also understand that this authorization will expire (Select One **): (KAR 30-60-47(b)(6), CFR-42, part 2)

☐ One year from this date (i.e., date of signature below).

OR ☐ On the following date: (not to exceed one year from this date)

OR ☐ Upon the following specific event, not to exceed one year from this date: (Please describe.)

** Note: If neither a specific date or a specific event is selected, this Authorization will automatically expire 90 days after discharge or one year from the date of the authorization, whichever comes first.

- I understand that if the person or organization authorized to receive this information is not a health care provider or a health plan or is not otherwise covered under the federal privacy regulations, the released information may be re-disclosed and will no longer be protected by federal privacy laws. I understand that certain persons or organizations may not re-disclose substance abuse treatment information. (CFR 42, part 2)
- I understand that this authorization is voluntary, and I verify that I have been given the chance to ask and receive answers to questions.

Consumer Signature: Date:

Authorized Representative Signature (if applicable): Date: Relationship to Client:

Witness (to Signature) Date:

* This information has been disclosed to you from records in which confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit the recipient from making any further disclosure of it without the specific written consent of the person to whom it pertains or except as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

MHA USE ONLY:

Action Requested:
☐ Send Request Immediately
☐ File

Action Taken:
(Date) Sent by
(Date) Filed by

**** A photostatic copy of this Authorization shall be considered as valid as the original. ****