AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A

Please print legibly

Client Last Name _____ First Name _____ MI _____ DOB _____

NA

Parent/Guardian Name (Last,First) * _____ Parent/Guardian Address(Street, City, Zip) _____ Phone # _____

Section B

I authorize **The Mental Health Association,** 555 N. Woodlawn, Suite 3105 Wichita, KS 67208 **to:**

MHA office address

Section C

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

_____ Admission Evaluation Report
_____ Diagnosis
_____ Treatment Plan(s)
_____ Psychiatric Consultation Report
_____ Psychological Evaluation Report
_____ Discharge Summary
_____ Progress Review(s)
_____ Alcohol Drug Treatment Information
(*See Next Page.)
_____ Hospitalization Screening
_____ Progress Notes: FROM _____ TO _____
_____ Medical _____
_____ Other: _____
_____ Other: _____
_____ Other: _____

Section D

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

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

Section E

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

Section F

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

_____
_____

Section G

TO / FROM - NAME / AGENCY _____
ADDRESS: _____
CITY, STATE, ZIP: _____

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

** Identification may be required to complete this form.*

EXPIRES: _____

Client ID:
Client Name:

Section H

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

_____ Evaluation / Treatment Planning _____ Case Coordination _____ Legal Proceedings
_____ School Placement or Assessment _____ Other _____

Section I: 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)

Section J: I also understand that MHA cannot ensure that the recipient will maintain confidentiality of this information I have authorized to be released.

Section K: 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)

Section L:

☐ One year from this date (i.e., date of signature below).
Or ☐ On the following date: _____(MM/DD/YY).
Or ☐ Upon the following specific event: (Please describe.) _____

** Note: If neither a specific date or special event is selected the Authorization will automatically expire 90 days after discharge or one year from the date of 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)

Section M: I understand that this authorization is voluntary, and I verify that I have been given the chance to ask and receive answers to questions.

_____

Section N: Signature of Client (required for minors receiving A/D treatment ages 14 and above) Date

_____

Signature of Authorized Representative (if applicable) Date **Section O:** Relationship to Client

_____

Section P: 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 disclosures 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) Sent by _____

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

EXPIRES: _____

Client ID:
Client Name: