

FOUR COUNTY MENTAL HEALTH CENTER, INC.
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
3751 W. MAIN / P.O. BOX 688
INDEPENDENCE, KS 67301

PATIENT NAME: _____ CASE NUMBER: _____

DATE OF BIRTH: ____ / ____ / ____ LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: _____

I HEREBY AUTHORIZE FOUR COUNTY MENTAL HEALTH CENTER TO RELEASE TO AND/OR OBTAIN FROM:

INDIVIDUAL/ORGANIZATION: PCP -

ADDRESS: _____

CITY/STATE/ZIP: _____ PHONE NUMBER: _____ FACSIMILE NUMBER: _____

THE FOLLOWING INFORMATION AS IS MINIMALLY NECESSARY: (PATIENT/LEGAL REPRESENTATIVE INITIAL APPROPRIATE BLANK)

RELEASE TO

- _____ SUMMARY OF TREATMENT TO INCLUDE DATES OF CONTACT, DIAGNOSIS, PROGNOSIS, TREATMENT PLAN, ADMISSION EVALUATION, DISCHARGE SUMMARY, MEDICAL PROGRESS NOTES, PSYCHIATRIC EVALUATION REPORT, PSYCHOLOGICAL EVALUATION REPORT AND RECOMMENDATIONS
- _____ ALCOHOL/DRUG TREATMENT INFORMATION, KCPC, EVALUATION, TREATMENT PLAN, DISCHARGE SUMMARY
- _____ PSYCHOTHERAPY PROGRESS NOTES
- _____ CURRENT NEEDS AND FUNCTIONING LEVEL
- _____ OTHER (SPECIFY): _____

OBTAIN FROM

- _____ SUMMARY OF TREATMENT TO INCLUDE DATES OF CONTACT, DIAGNOSIS, PROGNOSIS, TREATMENT PLAN, ADMISSION EVALUATION, DISCHARGE SUMMARY, MEDICAL PROGRESS NOTES, PSYCHIATRIC EVALUATION REPORT, PSYCHOLOGICAL EVALUATION REPORT AND RECOMMENDATIONS
- _____ ALCOHOL/DRUG TREATMENT INFORMATION, KCPC, EVALUATION, TREATMENT PLAN, DISCHARGE SUMMARY
- _____ MEDICAL RECORDS
- _____ SCHOOL REPORT REGARDING GRADES AND CONDUCT
- _____ OTHER (SPECIFY): MEDICAL REPORTS

THE PURPOSE OR NEED IS TO: (PATIENT/LEGAL REPRESENTATIVE INITIAL APPROPRIATE BLANK)

- _____ TO ASSIST THE PERSON(S) OR ORGANIZATION TO WHOM THE DISCLOSURE IS BEING MADE IN THEIR PROVISION OF SERVICES
- _____ TO OBTAIN INFORMATION IMPORTANT IN EVALUATION, TREATMENT AND SERVICE PROVISION
- _____ OTHER (SPECIFY): _____
- _____ OTHER (SPECIFY): _____

THIS CONSENT TO DISCLOSE MAY BE REVOKED BY ME AT ANY TIME UPON MY WRITTEN REQUEST EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THIS CONSENT (UNLESS EXPRESSLY REVOKED EARLIER) EXPIRES UPON: (PATIENT/LEGAL REPRESENTATIVE INITIAL APPROPRIATE BLANK)

- _____ CLOSE OF CASE AT FOUR COUNTY MENTAL HEALTH CENTER, INC.
- _____ DELIVERY OF REQUESTED INFORMATION
- _____ COMPLETION OF CONSULTATION
- _____ OTHER (SPECIFY): _____

PRINTED NAME OF PERSON AUTHORIZING THE RELEASE (PATIENT OR AUTHORIZED REPRESENTATIVE):

PATIENT SIGNATURE: _____ DATE: ____ / ____ / ____

PARENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE: _____ ADDRESS/PHONE: _____ DATE: ____ / ____ / ____
RELATIONSHIP: _____ () - _____

WITNESS SIGNATURE: _____ DATE: ____ / ____ / ____

****PLEASE READ THE ENTIRE FORM, BOTH FRONT AND BACK PAGES, BEFORE SIGNING****

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BY COMPLETING AND SIGNING THIS AUTHORIZATION:

THE INDIVIDUAL AUTHORIZING USE/DISCLOSURE OF THE PRIVATE HEALTH INFORMATION IDENTIFIED ON THE REVERSE SIDE OF THIS FORM ACKNOWLEDGES THAT HE/SHE IS AWARE THAT CERTAIN INFORMATION THAT HE/SHE IS CONSENTING TO RELEASE IS CONFIDENTIAL AND PROTECTED BY FEDERAL AND STATE LAW. THE AUTHORIZING INDIVIDUAL ACKNOWLEDGES UPON SIGNING THIS CONSENT THAT THEY ARE WAIVING THEIR RIGHTS UNDER THESE LAWS AND THAT THEY ARE AWARE OF THE SPECIFIC PROTECTIONS THEY ARE AFFORDED OR THEY ARE WAIVING THEIR RIGHT TO BE INFORMED OF THE SPECIFIC PROVISIONS OF THESE LAWS. THE AUTHORIZING INDIVIDUAL ACKNOWLEDGES THAT INFORMATION USED OR DISCLOSED PURSUANT TO THE AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE AUTHORIZED RECIPIENT, RESULTING IN THE INFORMATION BEING NO LONGER PROTECTED.

THE AUTHORIZING INDIVIDUAL UNDERSTANDS THAT SAID INFORMATION DISCLOSED MAY CONTAIN PSYCHIATRIC (K.S.A. 59-2946), SUBSTANCE ABUSE (STATUTE – 42 CFR-PART 2) AND/OR HIV/AIDS (OR OTHER COMMUNICABLE DISEASE K.S.A. 65-6001, -6004, -6008, -6009, -6016m, AND 60-427) INFORMATION.

THE AUTHORIZING INDIVIDUAL UNDERSTANDS, ACKNOWLEDGES, AND WAIVES HIS/HER RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION DESIGNED FOR THE USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION REQUESTED BY FOUR COUNTY MENTAL HEALTH CENTER AND IS FULLY AWARE THAT FOUR COUNTY MENTAL HEALTH CENTER WILL NOT LIMIT, CONDITION, OR DENY TREATMENT BASED UPON A REFUSAL TO SIGN AN AUTHORIZATION FOR USE OR DISCLOSURE OF PRIVATE HEALTH INFORMATION.