

**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: SCHOOL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_ FACSIMILE NUMBER: \_\_\_\_\_

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

**RELEASE TO**

**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
- \_\_\_\_\_ PSYCHOTHERAPY PROGRESS NOTES
- \_\_\_\_\_ CURRENT NEEDS AND FUNCTIONING LEVEL
- \_\_\_\_\_ OTHER (SPECIFY):  
PROVIDE VERBAL REPORTS ABOUT NEEDS, FUNCTIONING LEVEL, DIAGNOSIS, TREATMENT PLAN AND PROGRESS

- \_\_\_\_\_ 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):  
SCHOOL REPORT REGARDING GRADES AND CONDUCT; CURRENT NEEDS AND FUNCTIONING LEVEL

**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
- \_\_\_\_\_ OTHER (SPECIFY):  
 \_\_\_\_\_

- \_\_\_\_\_ TO OBTAIN INFORMATION IMPORTANT IN EVALUATION, TREATMENT AND SERVICE PROVISION
- \_\_\_\_\_ 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.