FOUR COUNTY MENTAL HEALTH CENTER, INC.
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
3751 W. MAIN / P.O. BOX 688
INDEPENDENCE, KS 67301

PATIENT NAME: _____ CLIENT ID: _____ DATE OF BIRTH: _____

I HEREBY AUTHORIZE FOUR COUNTY MENTAL HEALTH CENTER TO: ☐ **RELEASE TO** ☐ **OBTAIN FROM** ☐ **RELEASE TO AND OBTAIN FROM**

AUTHORIZED INDIVIDUAL/ ORGANIZATION: _____ **IF INDIVIDUAL, RELATIONSHIP TO PATIENT**: _____

ADDRESS: _____ **CITY:** _____

STATE/ZIP: _____ **PHONE NUMBER:** _____ **FAX NUMBER:** _____

THE FOLLOWING INFORMATION AS IS MINIMALLY NECESSARY (PATIENT/LEGAL REPRESENTATIVE, CHECK EACH ITEM BEING RELEASED / OBTAINED):

- ☐ Summary of treatment not limited to dates of contact, diagnosis, treatment plan, admission evaluation, discharge summary, medical records, therapy progress notes, psychiatric evaluation report, psychological evaluation report and recommendations*
- ☐ Alcohol/Drug treatment progress, SUD assessment/evaluation, treatment plan, discharge summary
- ☐ Current needs and functioning level
- ☐ School report regarding grades and conduct
- ☐ Disclosure Limited To (Ex. Appointments, Billing, Acknowledgement of services, Diagnosis):

_____

*__Disclaimer__: these MH records may contain SUD information including past and present use, diagnosis, and treatment history

THE PURPOSE OR NEED IS TO: PROVISION OF SERVICE AND/OR CARE COORDINATION.

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 EXPIRES ONE YEAR FROM THE DATE SIGNED. I UNDERSTAND AND ACCEPT THAT UPON FOUR COUNTY MENTAL HEALTH CENTER'S RECEIPT OF THIS WRITTEN REQUEST FOR REVOCATION THE REQUEST WILL BE MADE EFFECTIVE NO LATER THAN THE END OF THE NEXT BUSINESS DAY.

EXPIRATION DATE (NOT TO EXCEED ONE YEAR): _____

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

_____

PATIENT SIGNATURE: DATE:

_____ ___/___/___

PARENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE: ADDRESS/PHONE: DATE:

_____ _____ ___/___/___

RELATIONSHIP: _____

_____ (___) ___-___

BY COMPLETING AND SIGNING THIS AUTHORIZATION:

THE INDIVIDUAL AUTHORIZING USE/DISCLOSURE OF THE PRIVATE HEALTH INFORMATION IDENTIFIED ABOVE ACKNOWLEDGES THAT HE/SHE IS AWARE THAT CERTAIN INFORMATION THAT HE/SHE IS CONSENTING TO RELEASE IS CONFIDENTIAL AND PROTECTED BY FEDERAL (HIPAA 45 CFR PART 160 & 164) AND STATE (KSA 65-5602 & 5603) 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.