AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Central Kansas Mental Health Center (CKMHC) • 809 Elmhurst Blvd. • Salina, Ks • 67401 • (785) 823-6322 • Fax: (785) 823-3109

CLIENT INFORMATION & LEGAL NAME (*please print legibly*):

Last Name	First Name	MI	Maiden/Former Name	Date of Birth	SSN
				/ /	- -

THIRD PARTY INFORMATION – Identify the entity with which disclosure is authorized

I, the client or legal representative, hereby authorize Central Kansas Mental Health Center and

Printed Individual/Agency Name	Relationship/Title	**Printed** Street Address/City/State/Zip

to exchange protected health information in the following manner (***check*** *all that apply*):

☐ **RELEASE /** ☐ **OBTAIN** the following written information:

☐ Evaluation/Assessment/Intake _____ ☐ Other: _____
☐ Medical/Medication Information _____ ☐ Other: _____
☐ Diagnosis/Treatment Plan/Discharge Summary ☐ Other: _____

DISCUSS the following information:

☐ Complete record; all relevant portions of the medical record as necessary to achieve the purpose of the disclosure
☐ Other: _____

RESTRICTIONS – Note any restrictions here: _____

PURPOSE FOR DISCLOSURE – The purpose will be evaluation/care coordination, as well as any need identified below (***check*** *all that apply*):

☐ School Placement or Assessment ☐ Legal Proceedings ☐ Other: _____

TERM – This authorization will remain valid for one year if no expiration date/event is specified below:

Expiration Date (MM/DD/YY) or **Expiration Event** (describe): _____

ACKNOWLEDGEMENTS – I understand the following:

This authorization (unless expressly revoked) will remain in effect until the designated expiration date or event (not to exceed one year). • I have the right to revoke this authorization, in writing, before it expires, except to the extent that action has already been taken, and may do so by completing and submitting CKMHC's Revocation of Authorization form. • Only information specified can be released to only the specified person/agency. • Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. CKMHC cannot ensure the recipient will maintain confidentiality of this information I have authorized to be released. • The records authorized for disclosure may contain mental health, alcohol/drug treatment, or AIDS/HIV or other communicable disease information. Certain entities may not re-disclose substance abuse treatment information. • If signing as a parent/guardian, the information disclosed may contain references about me/my family. • This authorization is voluntary, as federal regulations prohibit conditioning of treatment, payment, enrollment/eligibility for benefits, with some exceptions, on provision of an authorization. • I verify that I have asked and received answers to any questions about this form. • A copy of this form is available to me upon my request. (KAR 30-60-47(b)(5), -(6), -(7); K.S.A. 65-4970; AAPS Standards for Licensure/Certification, Chapter 7, 1.a.(7); CFR-42, Part 2, and § 164.508)

SIGNATURES & AUTHORITY – Must be signed by person with legal authority to grant disclosure; identification may be required

X		/ /
Client Signature (age 14 or older)	**Printed** Name of Client	Date
X		/ /
Legal Representative (Parent/Guardian) Signature	**Printed** Name of Legal Representative (Parent/Guardian)	Date
		( ) -
Legal Representative's Relationship to Client	Legal Representative's Address (Street/City/State/Zip)	Legal Representative's Phone #
X		/ /
Witness Signature	**Printed** Name of Witness	Date

PROHIBITION OF RE-DISCLOSURE: 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. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

CKMHC USE ONLY **Action Requested:**
☐ **FILE** _____ ☐ **REQUEST** by **Fax** _____ ☐ **REQUEST** by **Mail** _____ ☐ **SEND** by **Fax** _____ ☐ **SEND** by **Mail** _____

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