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

	ON & LEGAL NAME (please print legib	<i>ly</i>):				
Last Name	First Name		Maiden/Former Name		Rirth	- SSN	-
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THIRD PARTY INFO	RMATION – Identify	the entity with whic	ch disclosure is authori	zed			
I, the client or legal	l representative, he	ereby authorize	e Central Kansas	Mental He	alth Ce	nter a	nd
Printed Individual/Agence							
to exchange protec	ted health informa	tion in the follo	owing manner (<i>ci</i>	heck all that a	ipply):		
☐ RELEASE / ☐ OB	TAIN the following writt	ten information:		DISCUSS th	e followin	g inforn	nation:
Medical/Medication Information				record; all relevant portions of the cord as necessary to achieve the the disclosure			
RESTRICTIONS - N	ote any restrictions here:						
PURPOSE FOR DISC	LOSURE - The purpose	e will be evaluation/ca	re coordination, as well a	as any need ider	ntified belo	w (<i>check</i>	k all that apply):
☐ School Placement or A	ssessment	Legal Proceedings	5 <u></u>	Other:			
TERM – This authoriz	ation will remain valid	for one year if no	expiration date/ev	ent is specifie	ed below	:	
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TERM – This authorize Expiration Date (MM,		•	•	•			
	/DD/YY) or Expiratio	n Event (describe	•	•			
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