SUMNER MENTAL HEALTH CENTER

1601 WEST 16TH STREET • PO BOX 607 • WELLINGTON KS 67152 • (620) 326-7448 • FAX (620) 326-6662

# AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, ______________________________________________________________________
(Patient's Name) Address (Date of Birth)

do hereby authorize ____________________________________ to release information
(Program Name)

contained in my patient records to the individual(s) or organization(s) listed below:

1. Name and Address of person(s) or organization(s) to whom disclosure is to be made:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

2. Specific type of information to be disclosed:
(Initial Appropriate Blanks)

- ☐ ______ Social History
- ☐ ______ Psychological Evaluation/ Testing Information
- ☐ ______ Court order
- ☐ ______ History and Physical
- ☐ ______ Treatment Progress
- ☐ ______ Intake Sheet
- ☐ ______ Progress Notes
- ☐ ______ Contact Summary

(Initial Appropriate Blanks)

- ☐ ______ Psychiatric Information
- ☐ ______ Academic Information/Classroom Behavior
- ☐ ______ Legal Information
- ☐ ______ Medical/Medication Information
- ☐ ______ Discharge Summary
- ☐ ______ Alcohol & drug Treatment History
- ☐ ______ Other, Please Specify

______________________________________________________________________

______________________________________________________________________

3. The purpose and need for such disclosure:

- ☐ ______ Care/Treatment, Ongoing
- ☐ ______ Treatment Planning
- ☐ ______ Assessment/Evaluation
- ☐ ______ To Bill Insurance for Payment of services

- ☐ ______ To Aid in Child Custody Case
- ☐ ______ To Aid in Court Case
- ☐ ______ To Follow Up Physician Referral
- ☐ ______ Other, Please Specify

______________________________________________________________________

______________________________________________________________________

I understand that my records (including any alcohol, drug abuse, or mental status information) are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except that action has been taken in reliance on it (e.g. probation, parole, etc) and that in any event this consent expires automatically as described below. Prohibition on redisclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 C.F.R. Part 2) prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense.

Drug abuse Office and Treatment Act of 1972(21 USC 1175) Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 &SC4582), Federal Register, Vol. 40,I No. 127, Tuesday, July 1, 1975

This **Authorization for the Release of Confidential Information** shall become effective on the date of execution of my signature hereinafter, and this **Authorization**, which grants specific authority for the release of protected health information by Sumner Mental Health Center, shall remain valid until (Date) __________ upon which date this **Authorization** shall automatically expire. I retain the right to revoke this **Authorization** at any time by providing a written notice to Sumner Mental Health Center, but I understand and agree that my consent to release information shall remain in effect until the date the revocation is date stamped in by the Medical Records Department, and any documents released previous to that date are considered to be authorized and approved by me.

______________________________
Signature of Client or Participant

______________________________
Printed Name of Client or Participant

Executed this _____ day of ____________, 20_____.

______________________________
Signature of Witness

______________________________
Signature of Representative

______________________________
Printed Name of Representative

______________________________
Description of representative's Authority

______________________________
Address Line 1 Phone

______________________________
Address Line 2 Date

(Form updated 10/2006)