Send
Request
File in Chart

Valeo Behavioral Health / Valeo Recovery Center / Valeo CRP (*Valeo*)
Authorization for Release of Protected Health Information

Identification may be required to complete this form.
A photostatic copy of this Authorization shall be considered as valid as the original.
Valeo cannot be responsible for the completeness or accuracy of records not prepared by or on behalf of Valeo.

REGARDING: _____ _____ _____
CLIENT'S FULL NAME | *DATE OF BIRTH (MM/DD/YYYY)* | *SOCIAL SECURITY NUMBER*

I, _____, the Client, Legal Guardian or Personal Representative hereby authorize **Valeo Behavioral Health / Valeo Recovery Center / Valeo CRP** (*Valeo*) to:

RELEASE the following written information:
(*Please mark* (i.e., ☒☑■) *each applicable entry*)

- ☐ Assessment/SPMI
- ☐ Diagnosis Sheet/Update
- ☐ Treatment Plan(s)/Reviews *(eff.8/4/08 could contain MH/AD)*
- ☐ Discharge Summary
- ☐ Med Evaluation
- ☐ Current Medication List/Medication Log
- ☐ Progress Note(s): FROM _____ (MM/DD/YYYY) TO _____ (MM/DD/YYYY)
- ☐ KCPC/ASI/CSR's
- ☐ Interpretive Summary
- ☐ TB Screening
- ☐ Lab
- ☐ Presence in Facility/Program
- ☐ Forms/Questionnaires
- ☐ UA/BAC
- ☐ Letters/Correspondence/E-mails *(encrypted)*
- ☐ Other: _____
  _____

OBTAIN the following written information:
(*Please mark* (i.e., ☒☑■) *each applicable entry*)

- ☐ H&P/ Evaluation Report
- ☐ Diagnosis Information Only
- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ Medication Sheet
- ☐ KCPC/ASI/CSR's
- ☐ Progress Note(s): FROM _____ (MM/DD/YYYY) TO _____ (MM/DD/YYYY)
- ☐ Lab
- ☐ Presence in Facility/Program
- ☐ Other: _____
  _____

VERBAL COMMUNICATION (*Please mark* (i.e., ☒☑■) *to authorize*)

☐ I authorize verbal communication in order to coordinate treatment, allow discussion of treatment progress, and discuss relevant concerns or issues regarding treatment.

RELEASE TO/OBTAIN FROM

AGENCY-:
ADDRESS: _____
CITY: _____ STATE: _ AK _ ZIP: _____

THIS DOCUMENT IS NOT VALID UNLESS THE INFORMATION IS COMPLETE ON THE REVERSE SIDE

RESTRICTIONS

The information indicated will be disclosed unless there are specific restrictions noted here:

_____

_____

PURPOSE OR NEED FOR THE DISCLOSURE (*Please mark* (i.e., ☒☑■) *all that apply*)

☐ Evaluation / Treatment Planning	☐ Case Coordination	☐ Legal Proceedings
☐ Authorization/Billing of KS Treatment Services	☐ Personal Record	☐ Client Well Being

☐ Other: _____

_____

- I understand that under state and federal confidentiality provisions only the information specified can be released to only the specified person or agency. (CFR-42, part 2, KAR 30-60-47(b)(5), AAPS guidelines, Chapter 7)
- I also understand that Valeo cannot assure that the recipient will maintain confidentiality of this information you have authorized to be released.
- I also understand that this authorization will be honored unless revoked in writing. Revocation may be made at any time except to the extent that action has already been taken. To revoke an authorization, I must complete the Revocation of Authorization Form or correspondence including all the elements of the Revocation of Authorization Form and forward to the **Health Information Management Department, 330 SW Oakley Ave, Topeka, KS 66606**. (KAR 30-60-47(b)(7), AAPS Standards for License/Certification, Chapter 7, 1.a.(7), and CFR-42, part 2)
- **I also understand that this release will expire:** _____ *(MM/DD/YYYY)* (KAR 30-60-47(b)(6), CFR-42, part 2) **(Release expires in 1 year unless otherwise specified - cannot exceed 1 year)**
- **I also understand that if I am under legal/court supervision/probation, this authorization will remain in effect and cannot be revoked by me until** (*Please mark* (i.e., ☒☑■) *if applicable*)**:**
  - ☐ **There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment.**
  - ☐ **Other time when authorization can be revoked:** _____ *(MM/DD/YYYY)*
- I also understand that this authorization is voluntary. I understand that if the person or organization authorized to receive this information is not a health care provider or a health plan or is not otherwise covered under the federal privacy regulations, the released information may be re-disclosed and will no longer be protected by federal privacy laws. I understand that certain person or organizations may not re-disclose substance abuse treatment information. (CFR 42, part 2)
- I understand these disclosures may contain information relating to HIV testing, HIV status, or AID; mental health treatment; substance use disorder treatment and/or medical treatment.
- I verify that I have asked and received answers to all questions and been offered/provided a copy of this release.

_____ _____

Signature of Client — *DATE SIGNED (MM/DD/YYYY)*

_____ _____

Signature of Legal Guardian or Personal Representative (if applicable) — *DATE SIGNED (MM/DD/YYYY)*

_____ _____

Signature of Witness — *DATE SIGNED (MM/DD/YYYY)*

FOR VALEO USE ONLY

Information Released: _____

Date Information Released: _____ *(MM/DD/YYYY)* By Whom: _____

How Released (*Please mark* (i.e., ●⊗) *one*): ◯ Phone ◯ Mail ◯ in Person ◯ Electronic ◯ Fax ◯ Other: _____

PROHIBITION ON REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES 42 CFR PART 2. THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42CFR, PART 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THE PURPOSE. THE FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT. 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 $5000 IN THE CASE OF EACH SUBSEQUENT OFFENSE.