Healthy Minds. Healthy Lives. Healthy Communities.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client Last Name ________ First Name ________ MI ________ Date of Birth ________

Parent/Guardian Name (Last, First) ________ Address (Street, City, Zip) ________ Phone # ________

I authorize Compass Behavioral Health to:

RELEASE the following written information:
(Please initial each applicable item)

- ___ Admission Evaluation Report
- ___ Diagnosis
- ___ Treatment Plan(s)
- ___ Psychiatric Consultation Report
- ___ Psychological Evaluation Report
- ___ Discharge Summary
- ___ Progress Review (s)
- ___ Alcohol & Drug Diagnosis
- ___ Alcohol & Drug Discharge Recommendations
- ___ Alcohol & Drug Evaluation
- ___ Alcohol & Drug Progress Notes
- ___ Alcohol & Drug Progress Review(s)
- ___ HCBS Waiver Information For Billing/Eligibility
- ___ HIV Testing, HIV Status or AIDS
- ___ Communication By Email
- ___ Communication By Texting
- ___ Hospital Screening
- ___ Progress Notes: FROM ________ TO ________
- ___ Medical ________
- ___ Housing Information ________
- ___ Other: ________

OBTAIN the following written information:
(Please initial each applicable item)

- ___ Admission Evaluation Report
- ___ Diagnosis
- ___ Treatment Plan(s)
- ___ Psychiatric Consultation Report
- ___ Psychological Evaluation Report
- ___ Discharge Summary
- ___ Progress Review (s)
- ___ Alcohol & Drug Diagnosis
- ___ Alcohol & Drug Discharge Recommendations
- ___ Alcohol & Drug Evaluation
- ___ Alcohol & Drug Progress Notes
- ___ Alcohol & Drug Progress Review(s)
- ___ HCBS Waiver Information For Billing/Eligibility
- ___ HIV Testing, HIV Status or AIDS
- ___ Communication By Email
- ___ Communication By Texting
- ___ Hospital Screening
- ___ Progress Notes: FROM ________ TO ________
- ___ Medical ________
- ___ Housing Information ________
- ___ Other: ________

I authorize verbal and written communication with the person or agency listed below in order to coordinate treatment, allow discussion of treatment progress, and discuss relevant concerns or issues regarding the above-named client's treatment.

TO / FROM – NAME / AGENCY ________

ADDRESS: ________

CITY, STATE, ZIP: ________ **PHONE:** ________

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

____

____

THE PURPOSE OR NEED FOR THE DISCLOSURE (Circle all that apply)

Evaluation / Treatment Planning Case Coordination Legal Proceedings Continuity of Care

School Placement or Assessment Other: ________

Healthy Minds. Healthy Lives. Healthy Communities.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION Cont'd

- I understand that under state and federal confidentiality provisions only the information specified can be released to the specified person or agency. (CFR-42, part 2, KAR 30-60-47 (b)(5), AAPS guidelines, Chapter 7)
- I also understand that Compass Behavioral Health cannot ensure that the recipient will maintain confidentiality of this information I have authorized to be released.
- I also understand that this authorization will be honored unless revoked verbally or in writing. Revocation may be made at any time except to the extent that action has already been taken. To revoke an authorization, I need to notify CBH. (KAR 30-60-47 (b)(7), AAPS Standards for Licensure/Certification, Chapter 7,1.a.(7), and CFR-42, part 2)
- 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 persons or organizations may not re-disclose substance abuse treatment information. (CFR-42, part 2)
- I understand that this authorization is voluntary, and I verify that I have been given the chance to ask and receive answers to questions.
- **I also understand that this authorization will expire** (Choose One): (KAR 30-60-47(b)(6), CFR-42, part 2)

One year from this date (i.e., date of signature below)

OR On the following date: ______________________________ (MM/DD/YYYY)

OR Upon the following specific event: (Please describe) ____________________________

** Note: If neither a specific date or a specific event is selected this Authorization <u>will automatically expire 90 days after discharge or one year from the date of authorization whichever comes first</u>.

____
Signature of Client (required for minors receiving A/D treatment ages 14 and above) Date

____
Signature of Authorized Representative (if applicable) Date Relationship to client

____
Witness (to signature) Date

EXPIRES: ____________________