# MENTAL HEALTH CENTER OF EAST CENTRAL KANSAS

1000 Lincoln Emporia, KS Phone: 800-279-3645 Fax: 620-342-1021

## AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Including Mental Health Information and/or Alcohol and Drug Treatment Records**

(Print legibly)

_____ _____ _____ _____

Client Last Name Client First Name MI Date of Birth SSN

Address: _____ Telephone #:_____

(City) (Zip)

**I, the undersigned (client, or Legal Representative) hereby authorize the Mental Health Center of East Central Kansas to:**

**RELEASE** the following written information:

**Please INITIAL each applicable item**

_____**X** Initial Assessment
_____**X** Diagnosis & Prognosis
_____ Treatment Plan(s)
_____ Psychiatric Consultation Report
_____ Psychological Evaluation Report
_____**X** Program Completion Report
_____ Hospitalization Screening
_____ Medical Reports:
_____**X** UA Drug Screening Results
_____**X** Recommendations:
_____**X** Alcohol & Drug Treatment Records
_____**X** Kansas Client Placement Criteria
_____**X** Progress Reports
_____**X** Psychosocial & Alcohol or Drug History
_____ Other (Be Specific):_____

**OBTAIN** the following written information:

**Please INITIAL each applicable item**

_____ Admission Evaluation Report
_____ Diagnosis & Prognosis
_____ Treatment Plan(s)
_____ Psychiatric Consultation Report
_____ Psychological Evaluation Report
_____ Discharge Summary
_____ Hospitalization Screening
_____**X** Criminal & Driving Offense Records
_____ Medical Reports: _____
_____**X** Recommendations:_____
_____
_____
_____**X** Other: (Be Specific)_____
_____
_____

**VERBAL COMMUNICATION** (**Please INITIAL if applicable**)

_____**X** I authorize verbal communication with the entity 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.

**PURPOSE OR NEED FOR DISCLOSURE: (Please INITIAL all that apply)**

| | | |
|---|---|---|
| ____Medical Emergencies | ____To Facilitate Referrals | ____School Placement or Assessment |
| ____Evaluation/Treatment Planning | ____To Advise the Court | ____To Transfer Treatment Providers |
| ____To Coordinate Treatment | ____To Advise Attorney | ____To Involve Family in Treatment |
| ____To Facilitate Consultation | ____To Facilitate Visitation | ___**X** Other (list below) |

_____**X** *To assist in assessing the client's compliance with conditions of probation and testify in court*

**TO / FROM Probation/Parole Officer:**_____ **PHONE #:** _____

**COURT:** _____

**CITY, STATE, ZIP:** _____**FAX #:**_____

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

**RESTRICTIONS (Please INITIAL your selection)** The information indicated will be disclosed unless there are specific restrictions noted below: _____NONE _____YES, Description as follows: _____

- 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 MHCECK cannot assure 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 will contact the Medical Records Director or my clinician to obtain appropriate forms to be completed i.e., the Revocation of Authorization Form and I will forward the completed form to Medical Records Director of MHCECK or my clinician. (KAR 30-60-47(b)(7), AAPS guidelines, Chapter 7,1.a.(7), and CFR-42, part 2)
- I also understand that this authorization will expire as indicated immediately below: (KAR 30-60-47(b)(6), CFR-42, part 2). **Please Note: This Authorization will automatically expire 90 days after discharge or one (1) year from the date of the signature below whichever comes first. (K.S.A. 65-4970)**
- 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 that this authorization waives the community mental health center-patient privilege described in K.S.A. 65-5601, 65-5602, 65-5603.
- I understand that this authorization is voluntary and treatment is not conditional upon my signing of the authorization (C.F.R. 164.508 ( c ) (2)(1). I verify that I have asked and received answers to my questions.

_____ _____ _____

Name of Client (Please **Print**) Date Client/Legally Authorized Representative **Signature**

_____ _____ _____

If Legally Authorized Representative, Please **Print** Name Date Relation to Client

(Enter address and phone # if different from client's)
Address: _____

City, State Zip Code

Telephone #: _____

_____ _____ _____

Witness (to Signature) Print Name Date

Note: Verification of information sent or received can be found in the client's Medical Record.

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or except as otherwise permitted by such regulations. 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. A photocopy or facsimile of this document is same as original for purpose of authorization for release of information.