

Southwest Guidance Center, Inc.

Authorization Requesting Use of Disclosure of Protected Health Information

I, hereby authorize disclosure of protected health information, which may include medical, psychiatric, psychological, and substance abuse treatment for:

Please print the following information:

Client Name: _____	DOB: _____
Social Security Number: _____	Phone: _____
Street Address: _____	
City: _____	State: _____ Zip Code: _____

Name of Person, Agency, or Provider information to be released to and/or requested from:

Name: _____	Phone: _____
Relationship to Client: _____	Fax: _____
Street Address: _____	
City: _____	State: _____ Zip Code: _____

The following **VERBAL** or **WRITTEN INFORMATION** will either be sent to or requested from: (Check all that apply)

- | | |
|--|--|
| ☐ Initial Admission Information | ☐ Billing Records |
| ☐ Diagnosis | ☐ Progress Reports |
| ☐ Treatment Plan (s) | ☐ Scheduling and Appointment Information |
| ☐ Psychological Evaluations/Reports/Screens | ☐ Progress Notes: From (date) _____ |
| ☐ Lab Reports | to (date) _____ |
| ☐ Medical Information | ☐ Other Information (<i>be specific</i>): _____ |
| ☐ Discharge Summary | |

Reason information is being released:	

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

Southwest Guidance Center, Inc.

Authorization Requesting Use of Disclosure of Protected Health Information

1. As to mental/nervous substance abuse records disclosed or used, I understand that these records shall not be disclosed without my express written permission. I understand that such information is subject to special protections pursuant to K.A.R. 30-60-47 (b)(5), the Health Insurance Portability and Accountability Act (HIPAA) (45 C.F.R. Parts 160, 162, and 164), and, when applicable, 42 C.F.R. Part 2.
2. I understand I have the right to revoke the authorization by delivering such revocation in writing or by verbal notice to the treatment provider, except to the extent they have acted in reliance thereon before notice of such revocation. Information about revocation is included in the Notice of Privacy Practice for Protected Health Information.
3. This office may not condition treatment, payment, enrollment, or eligibility for benefits on my providing and signing this authorization for this use or disclosure of my protected health information.
4. I understand that, ***except for psychotherapy notes as prohibited by Federal HIPAA law, and certain other limited exceptions under federal law***, I may inspect and obtain a copy of my protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that if use or disclosure of the requested information will result in any payment of fees to the above-named office from a third party, such payment of fees will be in accordance with applicable law.

5. This authorization will expire on X_____ (initials)
(Expiration date cannot exceed one (1) calendar year from signature date below.)

I hereby authorize Southwest Guidance Center to release/obtain information on my/my child's behalf as defined above.

Client/Guardian Signature

Date

Witness Signature

Date

Other

Date