

Revocation Date: ____/____/____

Expiration Date: ____/____/____

Spring River Mental Health & Wellness, Inc.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

☐ **Riverton Office**
6610 SE Quakervale Road P.O. Box 550
Riverton, KS. 66770
Phone: 620-848-2300 Fax: 620-848-2301

☐ **Columbus Office**
201 W. Walnut P.O. Box 126
Columbus, KS. 66725
Phone: 620-429-1860 Fax: 620-429-1041

☐ **Mental Health Information Only**

☐ **SUD Information Only**

Client First Name: _____ MI: _____ Last Name: _____

DOB: ____/____/____ I.D. # **OR** last 4 digits of SSN: _____

SPRING RIVER MENTAL HEALTH & WELLNESS, INC. IS HEREBY AUTHORIZED TO RELEASE AND/OR OBTAIN THE INFORMATION INDICATED BELOW:

☐ **RELEASE** the following information in either written and/or verbal format:

Date Range: ____/____/____ to ____/____/____

- ☐ Acknowledgement of Treatment
- ☐ Billing &/OR Insurance Information
- ☐ Intake/Admission Information
- ☐ Treatment Plan(s)/Waiver POC **(includes all documents)**
- ☐ Diagnosis
- ☐ Psychological Evaluation(s) Reports
- ☐ Psychiatric Evaluation(s)
- ☐ Medications Prescribed
- ☐ Discharge Summary/Plan
- ☐ Progress Notes
- ☐ Progress Review/Summary
- ☐ Screening Assessment(s)
- ☐ KCPC **(only with permission of SUD Counselor)**
- ☐ AAPS Eligibility Documents
- ☐ Treatment Participation
- ☐ Medical History, Lab Results, Immunization Records
- ☐ Other: _____
- ☐ Other: _____

☐ **OBTAIN** the following information in either written and/or verbal format:

Date Range: ____/____/____ to ____/____/____

- ☐ Acknowledgement of Treatment
- ☐ Billing &/OR Insurance Information
- ☐ Intake/Admission Information
- ☐ Treatment Plan(s)/Waiver POC **(includes all documents)**
- ☐ Diagnosis
- ☐ Psychological Evaluation(s) Reports
- ☐ Psychiatric Evaluation(s)
- ☐ Medications Prescribed
- ☐ Discharge Summary/Plan
- ☐ Progress Notes
- ☐ Progress Review/Summary
- ☐ Medical History, Lab Results, Immunization Records
- ☐ School Records/Reports/ IEP's
- ☐ KCPC
- ☐ Legal Documents (specify): _____
- ☐ Health Screenings (includes KBH & Well Child Visit)
- ☐ Other: _____
- ☐ Other: _____

Name/Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

PURPOSE OR NEED FOR THE DISCLOSURE:

- ☐ Process insurance/third party claims (Substance Abuse Remittance Only)
- ☐ Requested by client or parent/guardian for their own use
- ☐ Care Coordination
- ☐ Other: _____

*This information has been disclosed to you from records in which confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit the recipient from making any further disclosure of it without the specific written consent of the person 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.

THIS IS A TWO SIDED DOCUMENT. BOTH SIDES MUST BE COMPLETED FOR THE AUTHORIZATION TO BE CONSIDERED VALID.

RESTRICTIONS: The following information may not be released as a part of this authorization: _____

- 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 understand Spring River Mental Health & Wellness, Inc. cannot ensure the recipient will maintain confidentiality of the information I have authorized to be released.
- I understand this authorization will be honored unless revoked. Revocation may be made at any time except to the extent action has already been taken. To revoke an authorization, I need to notify SRMHW, Inc. and revoke the authorization in writing. (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 release this information is not a health care provider, 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 certain persons or organizations may not re-disclose substance abuse treatment information. (CFR 42, part 2)
- I understand the treatment records may include medical, psychiatric, substance abuse &/or HIV information.
- I understand this authorization will expire in one (1) year from the date of signature, or 90 days from the date of discharge from SRMHW unless one of the following is selected: ☐ 30 days ☐ 60 days ☐ 90 days ☐ specific event: _____ (KS 65-4970, KAR 30-60-47(b)(6), CFR-42, part 2)
- I understand this authorization is voluntary, and I verify that I have been given the chance to ask and receive answers to questions.

Treatment will not be conditioned upon your signing this authorization

Client Signature (age 14 or older) Client Printed Name ____/____/____
Date

Parent/Guardian Signature Parent/Guardian Printed Name Relationship to Client ____/____/____
Date

Parent/Guardian Address Phone #

Name of person who obtained this authorization ____/____/____
Date

☐ Client verbally revoked authorization. Date: ____/____/____ Staff Signature & Date: _____

☐ Authorization revoked by client/or guardian by attached written statement dated _____

****Revocation Disclaimer for Substance Abuse Services Only:** I understand that if treatment is mandated by the court system, permission for disclosure cannot be revoked until I am officially released from confinement, parole, or probationary status. **

**** A photo static copy of this Authorization shall be considered as legally valid****