



Substance Abuse Center of Kansas, Inc.

Specializing in the prevention and treatment of individuals and families affected by substance abuse.

Client Name: _____

Date of Birth: _____

I authorize and request the Substance Abuse Center of Kansas to communicate with the following individual's, providers, and /or agencies to exchange (send and receive) through disclosure and/or redisclosure information needed to coordinate and assist in coordinating my care, treatment and services.

Name of provider/agency, City/State

The information to be communicated includes the following:

___ Name/Presence in Treatment

___ Evaluation/Recommendations

___ Diagnosis

___ UA/BA Results

___ Identifying Information

___ Medical History

___ KCPC History

___ Discharge Information

___ Treatment Plan

___ Attendance Record

___ Emergency Information

___ Services Rendered

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier and in writing, this consent will expire automatically 180 days from the completion of services.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or Healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Upon Request I will be provided a copy of this form

Patient Signature

Date

Witness Signature

Date

Signature of person signing form if not patient

Describe authority to sign on behalf of patient _____