



SUMNER MENTAL HEALTH CENTER

1601 WEST 16TH STREET • PO BOX 607 • WELLINGTON KS 67152 • (620) 326-7448 • FAX (620) 326-6662

AUTHORIZATION FOR REQUESTING AND DISCLOSING PROTECTED HEALTH INFORMATION

Consumer Name:	DOB:	Address:
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☐ Disclose information to ☐ Request information from ☐ Exchange information with (obtain and/or disclose)

Name:

Relationship:

Address:

Phone (optional):

Fax (optional):

☐ Revoked on:

Check/initial specific information being authorized to be released or obtain: (Unless you specifically restrict any checked information by date or otherwise, all of the marked information may be released/obtained)

- | | |
|---|--|
| ☐ Admission/Intake/KCPC | ☐ Discharge Summary |
| ☐ Psychological Evaluation Report/Testing | ☐ Medical History/Labs |
| ☐ Presence in Treatment | ☐ Medication Management Information |
| ☐ Substance Abuse Evaluation Report | ☐ Substance Abuse Treatment History |
| ☐ Treatment Plan | ☐ Court/Legal reports/consultation |
| ☐ Verbal/Written progress reports/consultation | |
| ☐ Drug Testing Results | |
| ☐ Other: | |

I understand that this information will be used for the purpose of:

- ☐ Evaluation/Assessment ☐ Treatment/Care ☐ Treatment/Case Coordination ☐ Court/Attorney
☐ Follow up Care/Referral ☐ Other

- I, the undersigned, have read and authorized the release and disclosure of the above designated Protected Health Information (PHI) by my checks and initials.
- This authorization shall remain in effect until _____ (date) at which time this authorization to disclose the identified PHI expires, but not later than one year (365 days) from the date listed below.
- You have a right to request a copy of this form and to request a copy of the information that is being disclosed.
- You do not have to sign this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits.
- I understand that Sumner Mental Health Center cannot assure that the recipient will maintain confidentiality of this information you have authorized to be released, and if that happens, it might no longer be protected by federal privacy laws.
- You have a right to revoke this authorization at any time. But if you revoke this authorization, the revocation will not affect the disclosure of any information that Sumner Mental Health Center has already sent to the recipient.
- If you authorized release of alcohol or substance use information to a healthcare organization that is not your treating provider, for the next two years, you have the right to find out who within that organization actually saw your information. You should contact the organization directly for that information.
- I understand Sumner Mental Health Center may charge fees to provide copies of records and will comply with the Kansas Open Records Act guidelines for this purpose.

Consumer/Legal Guardian/Representative Signature

Witness Signature

Printed Name of Consumer/Parent/Guardian/Representative
Signing This Authorization

Date

(42 C.F.R. Part 2: Prohibition of Redisclosure: The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. 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).