

Office Use ONLY
Immediate Action Needed: ☐ File Only ☐ Request Records ☐ Request Sent ☐ Staff Signature

Name of Client (Maiden Name, if applicable) Last 4 digits of SSN DOB JCMHC ID

I hereby authorize **Johnson County Mental Health Center:** ☐ to disclose to AND/ OR ☐ to receive from

(agency, program, or individual, if an individual, identify relationship to client)

Address _____ City/State _____ Zip Code _____

Phone _____ Fax Number _____ Email _____

Type of records authorized to be disclosed, one or both record types must be marked to be a valid authorization ☐ Mental Health and/or ☐ Substance Abuse

JCMHC to Disclose (mark each that apply)

- ☐ Acknowledgement of Treatment
- ☐ Billing and/or Insurance Info
- ☐ Diagnosis
- ☐ Discharge Summary / Plan
- ☐ Intake / Admission Information
- ☐ KCPC (Electronic Version ONLY)
- ☐ Labs
- ☐ Med/Psych Notes (date range) _____ / _____ / _____ to _____ / _____ / _____
- ☐ Medications Prescribed
- ☐ Other: _____
- ☐ Other: _____
- ☐ Plan of Care / Treatment Plan
- ☐ Progress Notes (date range) _____ / _____ / _____ to _____ / _____ / _____
- ☐ Progress Summary (letters)
- ☐ Psychiatric Eval/Reports
- ☐ Psychological Eval/Reports
- ☐ TB Results
- ☐ UA

JCMHC to Receive (mark each that apply)

- ☐ Acknowledgement of Treatment
- ☐ Billing and/or Insurance Info
- ☐ Child Welfare Placement
- ☐ Diagnosis
- ☐ Discharge Summary / Plan
- ☐ Immunization
- ☐ Intake / Admission Information
- ☐ KCPC (Electronic Version ONLY)
- ☐ Labs
- ☐ Med/Psych Notes (date range) _____ / _____ / _____ to _____ / _____ / _____
- ☐ Medical History
- ☐ Medications Prescribed
- ☐ Other: _____
- ☐ Plan of Care / Treatment Plan
- ☐ Progress Notes (date range) _____ / _____ / _____ to _____ / _____ / _____
- ☐ Progress Summary (letters)
- ☐ Psychiatric Eval/Reports
- ☐ Psychological Eval/Reports
- ☐ School Report/IEP/504
- ☐ TB Results
- ☐ UA
- ☐ Waiver Documents

I understand this information will be used for **the following purpose(s):**

- ☐ Coordinating Client Care/Treatment
- ☐ Coordinating Client Care and Billing/Reimbursement
- ☐ Court Testimony (Subpoena Required)
- ☐ Emergency Contact
- ☐ Records are Requested by the Client/Guardian for Personal Use
- ☐ Other: _____

*I understand that the healthcare information may include medical, psychiatric, alcohol and drug abuse, diagnosis or treatment &/or HIV information. Unless otherwise specified, health care records within the last six months of services will be disclosed. I understand that my records are protected by law and cannot be disclosed or re-disclosed without my consent. However, records disclosed from Johnson County Mental Health Center to a non-covered entity may be subject to re-disclosure and no longer protected. I understand that I am not required to authorize the disclosure of my protected healthcare information to receive treatment. I may request a copy of this authorization and the information disclosed. I may revoke this authorization, in writing, at any time with the exception of situations in which Johnson County Mental Health Center has taken action in reliance on the authorization. A photo or electronic copy of this authorization is considered as valid as the original. By signing this authorization I acknowledge I have read and understand the disclosures I have authorized and I have the legal right and authority to sign this document. **Unless I revoke it earlier, this consent will expire in 365 days, or other length of time indicated.***

☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days

Signature of Client (age 14 or older) Printed Name of Client Date Signed

Signature of Parent or Legal Guardian Printed Name of Parent or Legal Guardian Date Signed

Client/Guardian may revoke the ROI verbally, by written statement or using the Revocation of Release of Information form. Revocation form and full policy is on our website: jocogov.org/mentalhealth or at any of our locations.

Revocation Disclaimer Substance Abuse Services Only: **If my treatment was ordered by the court, this permission cannot be revoked until I am officially released from confinement, parole, or probation

Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by law. 42 CFR Part 2 and other state and federal laws prohibits unauthorized disclosure of these records.

Instructions for Completing the Authorization to Disclose Protected Healthcare Information

1. Complete the first section with your current name and/or maiden name, last 4 digits of your social security number (SSN), date of birth, and Johnson County Mental Health Center ID.
2. **I hereby authorize Johnson County Mental Health Center (JCMHC):** Check the appropriate box. If records are being sent to someone other than the patient, then specify whom the records should be released, along with the address, phone number, fax number, and email.
3. **Type of records authorized to be disclosed:** Check the appropriate box on what type of records can be released, Mental Health and/or Substance Abuse.
4. **JCMHC to Disclose:** Mark the documents that you are authorizing JCMHC to release. If Med/Psych Notes or Progress notes are check marked, then specify the treatment dates. Please list specific dates; past year or past two years. If you do not remember the specific dates please indicate at least a time frame such as last month, last six months, etc.
5. **JCMHC to Receive:** Mark the documents that you are authorizing JCMHC to receive. If Med/Psych Notes or Progress notes are check marked, then specify the treatment dates. Please list specific dates; past year or past two years. If you do not remember the specific dates please indicate at least a time frame such as last month, last six months, etc.
6. **I understand this information will be used for the following purpose(s):** Check mark the appropriate box.
7. **Client/Personal Representative Signature:** This form should be signed by the patient. If the patient is unable to sign and the request is being made by an authorized personal representative of the patient (parent of a minor, Legal Guardian, person named on Power of Attorney, executor of estate, etc.), the Personal Representative should sign and date the form. Supporting legal documentation must accompany this authorization form when signed by a personal representative.
8. **If records are going to be picked up by someone other than the patient, then please inform JCMHC Medical Records.** Please provide medical records with the name, phone number, and address of the individual who will be picking up your medical records. A driver's license or photo ID will be required to be shown at the time of picking up the medical records.

Please email or call JCMHC Medical Records at 913-826-1537 if you have any further questions.

**The Johnson County Mental Health Center – Medical Records
6000 Lamar, Suite 130, Mission, Kansas 66202**

Attach Signed Form to E-Mail: MNH-MedRecords@jocogov.org or Fax: 913-826-1534