FOUR COUNTY MENTAL HEALTH CENTER, INC.
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
3751 W. MAIN / P.O. BOX 688
INDEPENDENCE, KS 67301

PATIENT NAME: _____ CASE NUMBER: _____

DATE OF BIRTH: ____/____/____ LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: _____

I HEREBY AUTHORIZE FOUR COUNTY MENTAL HEALTH CENTER TO RELEASE TO AND/OR OBTAIN FROM:

INDIVIDUAL/ORGANIZATION: _____
ADDRESS: _____ **CITY:** _____
STATE/ZIP: _____ **PHONE NUMBER:** _____ **FACSIMILE NUMBER:** _____

THE FOLLOWING INFORMATION AS IS MINIMALLY NECESSARY: (PATIENT/LEGAL REPRESENTATIVE INITIAL APPROPRIATE BLANK)

RELEASE TO:		**OBTAIN FROM:**	
☐ _____	SUMMARY OF TREATMENT TO INCLUDE DATES OF CONTACT, DIAGNOSIS, PROGNOSIS, TREATMENT PLAN, ADMISSION EVALUATION, DISCHARGE SUMMARY, MEDICAL PROGRESS NOTES, PSYCHIATRIC EVALUATION REPORT, PSYCHOLOGICAL EVALUATION REPORT AND RECOMMENDATIONS	☐ _____	SUMMARY OF TREATMENT TO INCLUDE DATES OF CONTACT, DIAGNOSIS, PROGNOSIS, TREATMENT PLAN, ADMISSION EVALUATION, DISCHARGE SUMMARY, MEDICAL PROGRESS NOTES, PSYCHIATRIC EVALUATION REPORT, PSYCHOLOGICAL EVALUATION REPORT AND RECOMMENDATIONS
☐ _____	ALCOHOL/DRUG TREATMENT INFORMATION, KCPC, EVALUATION, TREATMENT PLAN, DISCHARGE SUMMARY	☐ _____	ALCOHOL/DRUG TREATMENT INFORMATION, KCPC, EVALUATION, TREATMENT PLAN, DISCHARGE SUMMARY
☐ _____	PSYCHOTHERAPY PROGRESS NOTES	☐ _____	MEDICAL RECORDS
☐ _____	CURRENT NEEDS AND FUNCTIONING LEVEL	☐ _____	SCHOOL REPORT REGARDING GRADES AND CONDUCT
☐ _____	DISCLOSURE LIMITED TO: (EX: APPOINTMENTS, BILLING, ACKNOWLEDGMENT OF SERVICES, DIAGNOSIS) _____	☐ _____	OTHER (SPECIFY): _____

THE PURPOSE OR NEED IS TO: (PATIENT/LEGAL REPRESENTATIVE INITIAL APPROPRIATE BLANK)

☐ _____	TO ASSIST THE PERSON(S) OR ORGANIZATION TO WHOM THE DISCLOSURE IS BEING MADE IN THEIR PROVISION OF SERVICES/CARE COORDINATION	☐ _____	TO OBTAIN INFORMATION IMPORTANT IN EVALUATION, TREATMENT AND SERVICE PROVISION/CARE COORDINATION
☐ _____	OTHER (SPECIFY): _____	☐ _____	OTHER (SPECIFY): _____

THIS CONSENT TO DISCLOSE MAY BE REVOKED BY ME AT ANY TIME UPON MY WRITTEN REQUEST EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THIS CONSENT EXPIRES ONE YEAR FROM THE DATE SIGNED. I UNDERSTAND AND ACCEPT THAT UPON FOUR COUNTY MENTAL HEALTH CENTER'S RECEIPT OF THIS WRITTEN REQUEST FOR REVOCATION THE REQUEST WILL BE MADE EFFECTIVE NO LATER THAN THE END OF THE NEXT BUSINESS DAY.

☐ _____ OTHER (SPECIFY DATE OR EVENT IF RELEASE TO EXPIRE IN LESS THAN ONE YEAR): _____
(PATIENT/LEGAL REPRESENTATIVE INITIAL)

PRINTED NAME OF PERSON AUTHORIZING THE RELEASE (PATIENT OR AUTHORIZED REPRESENTATIVE):
_____

PATIENT SIGNATURE: _____ DATE: ____/____/____

PARENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE: _____ ADDRESS/PHONE: _____ DATE: ____/____/____

RELATIONSHIP: _____ ( ) -

WITNESS SIGNATURE: _____ DATE: ____/____/____

****PLEASE READ THE ENTIRE FORM, BOTH FRONT AND BACK PAGES, BEFORE SIGNING****

BY COMPLETING AND SIGNING THIS AUTHORIZATION:

THE INDIVIDUAL AUTHORIZING USE/DISCLOSURE OF THE PRIVATE HEALTH INFORMATION IDENTIFIED ON THE REVERSE SIDE OF THIS FORM ACKNOWLEDGES THAT HE/SHE IS AWARE THAT CERTAIN INFORMATION THAT HE/SHE IS CONSENTING TO RELEASE IS CONFIDENTIAL AND PROTECTED BY FEDERAL AND STATE LAW. THE AUTHORIZING INDIVIDUAL ACKNOWLEDGES UPON SIGNING THIS CONSENT THAT THEY ARE WAIVING THEIR RIGHTS UNDER THESE LAWS AND THAT THEY ARE AWARE OF THE SPECIFIC PROTECTIONS THEY ARE AFFORDED OR THEY ARE WAIVING THEIR RIGHT TO BE INFORMED OF THE SPECIFIC PROVISIONS OF THESE LAWS. THE AUTHORIZING INDIVIDUAL ACKNOWLEDGES THAT INFORMATION USED OR DISCLOSED PURSUANT TO THE AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE AUTHORIZED RECIPIENT, RESULTING IN THE INFORMATION BEING NO LONGER PROTECTED.

THE AUTHORIZING INDIVIDUAL UNDERSTANDS THAT SAID INFORMATION DISCLOSED MAY CONTAIN PSYCHIATRIC (K.S.A. 59-2946), SUBSTANCE ABUSE (STATUTE – 42 CFR-PART 2) AND/OR HIV/AIDS (OR OTHER COMMUNICABLE DISEASE K.S.A. 65-6001, -6004, -6008, -6009, -6016m, AND 60-427) INFORMATION.

THE AUTHORIZING INDIVIDUAL UNDERSTANDS, ACKNOWLEDGES, AND WAIVES HIS/HER RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION DESIGNED FOR THE USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION REQUESTED BY FOUR COUNTY MENTAL HEALTH CENTER AND IS FULLY AWARE THAT FOUR COUNTY MENTAL HEALTH CENTER WILL NOT LIMIT, CONDITION, OR DENY TREATMENT BASED UPON A REFUSAL TO SIGN AN AUTHORIZATION FOR USE OR DISCLOSURE OF PRIVATE HEALTH INFORMATION.