



CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

304 N. Jefferson
PO Box 807
Iola, KS 66749

402 S. Kansas
Chanute, KS 66720

519 S. Elm
Garnett, KS 66032

212 State St.
Fort Scott, KS 66701

505 W. 15th
Pleasanton, KS 66075

1106 S. 9th
PO Box 39
Humboldt, KS 66748

204 S. Main
Yates Center, KS
66783

Client Name	Client Case #
Client Address	
Date of Birth	Phone #

I hereby authorize the Southeast Kansas Mental Health Center to <input type="checkbox"/> release to <input type="checkbox"/> obtain from	the following information: From: _____ To: _____
<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <i>Organization/Individual Name/Relationship</i> <i>Address</i> <i>Telephone/Fax</i> </div> <div style="border: 1px solid black; padding: 5px;"> The purpose or need is to: <input type="checkbox"/> Assist in the provision of services <input type="checkbox"/> Legal/Court ordered <input type="checkbox"/> Personal use <input type="checkbox"/> School <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Other: _____ <input type="checkbox"/> Coordination of Treatment <input type="checkbox"/> Other: _____ </div>	<div style="border: 1px solid black; padding: 5px;"> <input type="checkbox"/> Admission Evaluation Report <input type="checkbox"/> Diagnosis Only <input type="checkbox"/> Treatment Plan(s) <input type="checkbox"/> Psychiatric Consultation Report <input type="checkbox"/> Psychological Evaluation Report <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Progress Review(s) <input type="checkbox"/> Alcohol and Drug Treatment information <input type="checkbox"/> Hospitalization Screening <input type="checkbox"/> Progress Notes: FROM _____ TO _____ <input type="checkbox"/> Medical Report <input type="checkbox"/> Legal Reports <input type="checkbox"/> Education Reports <input type="checkbox"/> Medications <input type="checkbox"/> Appointments <input type="checkbox"/> Other _____ <input type="checkbox"/> Other: _____ </div>

Expiration This authorization shall remain in effect until _____ at which time this authorization expires, but no later than one year (month/day/year) from the date listed below. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing verbal or written notice of revocation to Southeast Kansas Mental Health Center. I understand that fees may be charged for preparing and sending copies of records. I acknowledge that I am aware that certain information that I am consenting to release is confidential and protected by Federal and State Law. I acknowledge upon signing this consent that I am waiving my rights under these laws and I am aware of the specific protections afforded or am waiving my rights to being informed of the specific provisions of these laws, Statute 42 CFR – Part 2. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the privacy regulations. I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization.

Client/Patient Signature		Date	
Parent/Guardian/Legal Representative		Date	
Relationship to Client			
Witness Signature		Date	