Southeast Kansas Mental Health Center

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

304 N. Jefferson
PO Box 807
Iola, KS 66749

402 S. Kansas
Chanute, KS
66720

1322 S. Grant
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
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
☐ release to ☐ obtain from

Organization/Individual Name/Relationship

Address

Telephone/Fax

The purpose or need is to:

- ☐ Assist in the provision of services
- ☐ Personal use
- ☐ Criminal Justice
- ☐ Coordination of Treatment
- ☐ Other: _____
- ☐ Legal/Court ordered
- ☐ School
- ☐ Other: _____

the following information:
From: _____ To _____

- ☐ Admission Evaluation Report
- ☐ Diagnosis Only
- ☐ Treatment Plan(s)
- ☐ Psychiatric Consultation Report
- ☐ Psychological Evaluation Report
- ☐ Discharge Summary
- ☐ Progress Review(s)
- ☐ Alcohol and Drug Treatment information
- ☐ Hospitalization Screening
- ☐ Progress Notes: FROM _____ TO _____
- ☐ MHC Treatment Report Form
- ☐ Medical Report
- ☐ Legal Reports
- ☐ Education Reports
- ☐ Medications
- ☐ Labs
- ☐ Appointments
- ☐ Billing
- ☐ Other _____
- ☐ Other: _____

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	