Southeast Kansas Mental Health Center

CAS - Consent for Release of Confidential Information

304 N. Jefferson
PO Box 807
Iola, KS 66749
620-365-5717
fax: 620-365-8255

1322 S. Grant
Chanute, KS 66720
620-431-7890
fax: 620-431-7927

519 South Elm
Garnett, KS 66032
785-448-6806
fax: 785-448-6960

401 Woodland Hills
Blvd. Box #6
Fort Scott, KS 66701
620-223-5030
fax: 620-223-1650

505 W. 15th
Pleasanton, KS 66075
913-352-8214
fax: 913-352-8236

1106 S. Ninth
PO Box 39
Humboldt, KS 66748
620-473-2241
fax: 620-473-3334

Client/Patient Name		Case Number	
Date of Birth		Social Security Number	

I hereby authorize Southeast Kansas Mental Health Center to__ ☐ **Release**__ ☐ **Obtain**

Name of Individual Agency			
Address, City, State, Zip			
Telephone Number		Fax Number	

the following information __ ☐ **Release** __ ☐ **Obtain**

___ ☐ Diagnostic Evaluation	___ ☐ Relapse Prevention Plan	__ ☐Referral for TB Screening/Evaluation
___ ☐ Verification of Compliance	___ ☐ Verification of Completion	__ ☐ TB Risk Assessment
___ ☐ Status Report	___ ☐ Service Requested	__ ☐ Results of TB Screening/Evaluation
___ ☐ Discharge Plan	___ ☐ Court Order	__ ☐ Client Compliance Documentation
___ ☐ Discharge Summary	___ ☐	__ ☐ Emergency Medical Information
___ ☐	___ ☐	__ ☐ Provide Insurance/Third Party Claim

The purpose or need is to

__ ☐	Assist in the provision of services	__ ☐	Advise compliance with recommendations
__ ☐	Communicate Medical Emergency	__ ☐	

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 will not exceed more than one year. This consent expires on _____.

I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. pts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Client Signature _____ Date _____

Parent/Guardian/
Legal Representative _____ Date _____

Relationship _____

Witness Signature _____ Date _____

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information, if held by another party is NOT sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be subject to penalties. Drug Abuse Office and Treatment Act of 1971 (21 USC 1175) Comprehensive Alcohol Abuse, Federal Register, V Col. 40 No 127-Tuesday, July 1, 1975.