

COMMUNITY MENTAL HEALTH CENTER OF CRAWFORD COUNTY

911 E. Centennial Pittsburg, KS 66762 Phone: 620-231-5130 Fax: 620-235-7101

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____	_____	_____	_____	_____
Last Name	First Name	MI	Date of Birth	SSN

Address, City, State, Zip Code				

I, _____, the client or legal representative, hereby authorize
(Identification may be required to complete this form)

COMMUNITY MENTAL HEALTH CENTER OF CRAWFORD COUNTY to:

RELEASE the following written information:
(Please initial each applicable item)

- Admission Evaluation Report
- Diagnosis Only
- Treatment Plan(s)
- Psychiatric Consultation Report
- Psychological Evaluation Report
- Discharge Summary
- Progress Review(s)
- Alcohol and Drug Treatment information
(* See Notation at Bottom of Restrictions.)
- Hospitalization Screening
- Progress Notes: FROM _____ TO _____
- Medical _____
- Other: _____
- Other: _____
- Other: _____

OBTAIN the following written information:
(Please initial each applicable item)

- 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 _____
- Medical Reports _____
- Legal Reports _____
- Education Reports _____
- Other: _____
- Other: _____

VERBAL COMMUNICATION (Please initial if applicable)

_____ I authorize verbal communication with the entity listed below in order to coordinate treatment, allow discussion of treatment progress, and discuss relevant concerns or issues regarding the above –named client’s treatment.

RESTRICTIONS – The information indicated will be disclosed unless there are specific restrictions noted here:

* 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 except as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be fined not more than \$500 in the case of a first offense and not more than \$5000 in the case of each subsequent offense. Drug Abuse Office and Treatment Act of 1972 (21 USC 1175) Comprehensive Alcohol Abuse, Federal Register, Vol. 40, no. 127-Tuesday July 1, 1975.

TO / FROM – NAME / AGENCY: _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____

PHONE NUMBER: _____ **FAX NUMBER:** _____

THIS DOCUMENT IS NOT VALID UNLESS THE INFORMATION IS COMPLETE ON REVERSE SIDE

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THE PURPOSE OR NEED FOR THE DISCLOSURE (Initial all that apply)

- Evaluation / Treatment Planning Case Coordination Legal Proceedings
 School Placement or Assessment Other _____

- I understand that under state and federal confidentiality provisions only the information specified can be released to only the specified person or agency. (CFR-42, part 2 , KAR 30-60-47(b)(5), AAPS guidelines, Chapter 7)
- I also understand that Community Mental Health Center of Crawford County cannot assure that the recipient will maintain confidentiality of this information you have authorized to be released.
- I also understand that this authorization will be honored unless revoked in writing. Revocation may be made at any time except to the extent that action has already been taken. **To revoke an authorization, I need to notify the Community Mental Health Center of Crawford County in writing as listed in the Notice of Privacy Practices.** (KAR 30-60-47(b)(7), AAPS Standards for Licensure/Certification, Chapter 7,1.a.(7), and CFR-42, part 2)
- ***I also understand that this authorization will expire (Select One **): (KAR 30-60-47(b)(6), CFR-42, part 2)***
***** Expiration Date on Releases cannot exceed one (1) year (KSA 65-4970)***

- One year from this date (i.e., date of signature below) On the following date: _____
 Upon completion of the following event (Please Describe): _____

****Note: If neither a specific date or a specific event is selected this Authorization will automatically expire 90 days from the date of signature below.**

- I understand that if the person or organization authorized to receive this information is not a health care provider or a health plan or is not otherwise covered under the federal privacy regulations, the released information may be re-disclosed and will no longer be protected by federal privacy laws. I understand that certain person or organizations may not re-disclose substance abuse treatment information. (CFR 42, part 2)
- I understand that the Center may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization when the Privacy Regulations prohibit such conditions of authorizations.
- I understand that this authorization is voluntary and I verify that I have asked and received answers to all questions.

Printed Name of Client Signature of Client Date

Printed Name of Authorized Representative Signature of Authorized Representative Relationship to Client Date

Authorized Representative's Address, City, State, Zip Code Signature of Witness Date

Printed Name of Witness Signature of Witness Date

**** A photostatic copy of this Authorization shall be considered as valid as the original. ****