5815 Broadway ♦ Great Bend, KS 67530
800-875-2544 ♦ 620-792-2544 ♦ 620-792-7052 (fax)

AUTHORIZATION TO OBTAIN AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

CLIENT INFORMATION					
Last Name:	First Name:	Middle:	Birth date:	Social Security #:	Client #:

Address:	City:	State:	Zip:

I, ______________________________ , the client or authorized representative, hereby authorize

The Center for Counseling & Consultation to:

DISCLOSE: (Please **initial** each applicable item)

_____ Admission Evaluation/Intake Report
_____ Diagnosis Only
_____ Discharge Summary
_____ Evaluation (specify):
_____ Hospitalization Screening
_____ Presence in Program
_____ Progress Notes (Case Mgmt.):________________
_____ Progress Notes (Medication):________________
_____ Progress Notes (Therapy):________________
_____ Progress Review(s)
_____ Treatment Plan(s)
_____ Other (specify):________________
_____ Other (specify):________________

OBTAIN: (Please **initial** each applicable item)

_____ Admission Evaluation/Intake Report
_____ Diagnosis Only
_____ Discharge Summary
_____ Education Reports (specify):
_____ Evaluation (specify):
_____ Hospitalization Screening
_____ Legal Reports (specify):
_____ Medical Records (specify):
_____ Progress Notes: From:__________To:__________
_____ Progress Review(s)
_____ Treatment Plan(s)
_____ Other (specify):________________
_____ Other (specify):________________

INFORMATION TO BE DISCLOSED AND/OR OBTAINED:	
Name:	Attn:

Fax Number:	Address:	City:	State:	Zip:

RESTRICTIONS:	
The information indicated will be disclosed and or obtained unless there are specific restrictions noted here:	

*This information has been disclosed to you from records in which confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit the recipient from making any further disclosure of it without the specific written consent of the person whom it pertains or except as otherwise permitted my such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

THIS DOCUMENT IS NOT VALID UNLESS THE INFORMATION IS COMPLETE ON SECOND PAGE

AUTHORIZATION TO OBTAIN AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

THE PURPOSE FOR DISCLOSURE AND/OR OBTAIN (INITIAL ALL THAT APPLY)

_____ Case Coordination
_____ Evaluation / Treatment Planning
_____ Legal Proceedings
_____ School Placement or Assessment
_____ Visit Facilitation
_____ Other (specify) ______________________________
____

EXPIRATION (INITIAL ONE APPROPRIATE OPTION)

THIS AUTHORIZATION FOR DISCLOSURE AND/OR OBTAIN OF HEALTH INFORMATION MAY BE REVOKED BY ME AT ANY TIME UPON RECEIPT OF MY **WRITTEN REQUEST** EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THIS AUTHORIZATION IS VALID UP TO A YEAR FROM THE DATE OF SIGNATURE (UNLESS INITIALED BELOW):

_____ Upon completion of treatment/evaluation
_____ On the following date:______-______-______

SIGNATURE

I acknowledge that certain information I am consenting to release is confidential and protected by Federal and State law. I acknowledge that, once disclosed, it may be subject to redisclosure by the recipient and no longer be protected by statutory limits. Provision of treatment will not be conditioned by failure to authorize and I am not obligated to sign this authorization. I am allowed the right to inspect or copy the information to be used or disclosed. (A copy of this authorization will be provided to me.)

	X	X
Date	Client Name Printed	Client Signature
	X	X
Date	Responsible Party/Guardian Name Printed	Responsible Party/Guardian Signature

(Specify relationship to Client) ______________________________ Telephone: ______________

Address: ______________________________ City: ______________ State: ________ Zip: ________

	X	X
Date	Witness Name Printed	Witness Signature

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