AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The purpose of this form is to authorize South Central Mental Health Counseling Center, Inc. (SCMHCC), 520 E. Augusta Ave., Augusta, KS 67010 to share protected health information with the identified third party for the purposes of treatment, payment and health care operations.

CLIENT:

_____ _____

Last Name *First Name* *MI* *Date of Birth*

I authorize SCMHCC to (initial all that apply):

☐ **exchange** ☐ **release to** ☐ **obtain from** ☒ **discuss with**

the third party identified below, specified protected health information listed below for the purposes of treatment, payment & health care operations.

INITIAL EACH APPLICABLE ITEM:

☐ Billing and/or Insurance Information	☒ Treatment Plan/Plan of Care
☐ Intake/Admission Summary	☐ Psychological Testing
☐ Diagnosis	☐ School Records
☐ Psychiatric Evaluation	☐ Progress Notes
☐ History & Physical	☐ Waiver Documents
☐ Medication List	☐ Lab Reports
☐ Treatment Review/Progress Report	☐ Chemical Dependency Evaluation
☐ Discharge Summary	☐ Alcohol/DUI Evaluation

☐ Other: _____

THIRD PARTY:

EMERGENCY CONTACT

_____

Organization/Individual Name *Relationship to Client*

_____

Address

_____

Telephone/Fax

This authorization shall remain in effect until_____ *(date)* at which time this authorization expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for one year from the date listed below.

I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records. 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 SCMHCC.

_____

Signature of Client *Date*

_____

Printed Name of Client *Address and Phone Number*

_____

Signature of Client Guardian *Date*

_____

Printed Name of Client Guardian and Relationship to Client *Guardian Address and Phone Number*

_____

Signature of Witness

☐ **Client verbally revoked ROI on: _____ Staff Signature and Date: _____**

☐ **Authorization revoked by client or guardian by attached statement dated: _____ ; or,**

☐ **I hereby revoke the above authorization to release confidential information.**

_____ _____ _____

Signature of Client (age 14 or older) *Signature of Client Guardian* *Date*

Revocation Disclaimer Substance Abuse Only:

If my treatment was mandated by the court, permission to release to the court cannot be revoked until I am officially released from confinement, parole or probation.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.