AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTECTED HEALTH INFORMATION

Section A:

Client Name:_____ Date of Birth:_____ SSN:_____

Parent/Guardian Name:_____ Phone #:_____

Address (City, ST, Zip):_____

Section B: I authorize KANZA Mental Health, 909 South 2nd Street, PO Box 319, Hiawatha, KS 66434 to:

Section C: **RELEASE** the following written information as categorized:

- ☐ ACCOUNT INFORMATION
- ☐ ADMISSION EVALUATION
- ☐ ALCOHOL & DRUG TREATMENT
- ☐ APPOINTMENTS
- ☐ CONSULTATIONS
- ☐ DIAGNOSIS DOCUMENTATION
- ☐ DISCHARGE DOCUMENTATION
- ☐ FINANCE/INSURANCE BILLING INFORMATION
- ☐ LEGAL DOCUMENTATION
- ☐ MEDICATIONS
- ☐ PROGRESS IN TREATMENT
- ☐ PSYCHIATRIC EVALUATION
- ☐ SCREENINGS
- ☐ TREATMENT PLAN
- ☐ OTHER:_____

_____

Section D: **OBTAIN** the following written information as categorized:

- ☐ ACCOUNT INFORMATION
- ☐ ADMISSION EVALUATION
- ☐ ALCOHOL & DRUG TREATMENT
- ☐ APPOINTMENTS
- ☐ CONSULTATIONS
- ☐ DIAGNOSIS DOCUMENTATION
- ☐ DISCHARGE DOCUMENTATION
- ☐ FINANCE/INSURANCE BILLING INFORMATION
- ☐ LEGAL DOCUMENTATION
- ☐ MEDICATIONS
- ☐ PROGRESS IN TREATMENT
- ☐ PSYCHIATRIC EVALUATION
- ☐ SCREENINGS
- ☐ TREATMENT PLAN
- ☐ OTHER:_____

_____

Section E: **VERBAL COMMUNICATION** – By my signature below, I authorize verbal communication with the person or agency 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.

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

_____

Section G:

TO / FROM – NAME / AGENCY:_____ **RELATIONSHIP:**_____

Address (City, ST, Zip):_____

Phone:_____ Fax:_____

THIS DOCUMENT IS NOT VALID UNLESS THE INFORMATION IS COMPLETED ON THE REVERSE SIDE (PAGE 2).

**** Identification may be required to complete this form.****

Section H: **THE PURPOSE OR NEED FOR THE DISCLOSURE (Check all that apply):**

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

_____

Section I: I understand that under State and Federal confidentiality provisions, only the information specified can be released to the specified person or agency. (CFR-42, part 2, KAR 30-60-47(b)(5), AAPS guidelines, Chapter 7)

Section J: I also understand that KANZA cannot ensure that the recipient will maintain confidentiality of this information I have authorized to be released.

Section K: I also understand that this authorization will be honored unless revoked verbally or 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 KANZA. (KAR 30-60-47(b)(7), AAPS Standards for Licensure Certification, Chapter 7,1.a(7), and CFR-42, part 2)

Section L: I also understand that this authorization will expire (Select one **): (KAR 30-60-47(b)(6), CFR-42, part 2)

- ☐ One year from this date (i.e. date of signature below)
- ☐ OR on the following date: _____ (MM/DD/YY)
- ☐ OR upon the following specific event (Please describe):_____

** NOTE: If neither a specific date or a specific event is selected, this Authorization will automatically expire 90 days after discharge or one (1) year from the date of authorization, whichever comes first.

I understand that if the person or organization authorization 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 persons or organizations may not re-disclose substance abuse treatment information (CFR-42, part 2).

Section M: I understand that this authorization is voluntary, and I verify that I have been given the chance to ask and receive answers to questions.

Signature of Client:_____ Date_____

_____ Date_____

Signature of Authorized Representative (if applicable)

Witness (to signature):_____ Date_____

- 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 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.

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

KANZA use only:

Action Requested:

- ☐ Send Request Immediately
- ☐ File

Action Taken:

- ☐ (Date) Sent by:_____
- ☐ (Date) Filed by:_____