CROSSWINDS COUNSELING & WELLNESS

1000 Lincoln Emporia, KS 66801 Phone: 800 279-3645 Fax: 620 342-1021

Please select action needed:

☐	Send Records
☐	Request Info
☐	Service Letter
☐	File in Chart
☐	Send release only

Authorization for the Disclosure of Protected Health Information

Including Mental Health Information and/or Alcohol and Drug Records

Client First Name:		Client MI:		Client Last Name:	
Date of Birth:		Address:			
City/State/Zip:			SSN:	Telephone #:	

The information may be released to/obtained from:

Name/Agency**:**	
Specific Staff/Title:	Email:
Address:	Telephone #:
City/State/Zip:	Fax #:

I agree that the **PURPOSE OR NEED FOR DISCLOSURE** is indicated below: (Please review and select below)

☐ To Coordinate Treatment/Consultation ☐ To Advise the Court/Attorney/CRB ☐ To Transfer Treatment Providers
☐ To Involve Family in Treatment ☐ To testify or participate in court proceedings
☐ Other (specify): _____

I, the undersigned (client or Legal Representative) hereby authorize **CrossWinds Counseling & Wellness:**

(If not completed on computer, boxes will need to be initialed by client/legal representative)

Crosswinds to: **Release**	Crosswinds to**: Obtain**	
☐	☐	Any Mental Health Treatment Records, which are minimally necessary, including the diagnosis and records of any treatment or evaluations rendered to me.
☐	☐	Any Alcohol, Drug or Substance Abuse information.
	☐	Medical/Lab Reports.
	☐	School reports regarding grades and conduct.
☐	☐	Other (Specify):

VERBAL COMMUNICATION

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

DISCLOSURE LIMITATIONS: The information indicated will be disclosed unless there are specific restrictions noted below:

THIS DOCUMENT IS NOT VALID UNLESS ACCOMPANIED WITH A SIGNATURE PAGE

- **I understand that this authorization will be honored unless revoked verbally or in writing and that it will be my responsibility to revoke any authorizations no longer relevant. Revocation may be made at any time except to the extent that the information has already been released; or the program which is to make the disclosure has already taken action in reliance on it.**
- To revoke an authorization, it will be my responsibility to contact the Medical Records Director or my clinician to obtain appropriate forms to be completed (i.e., the Revocation of Authorization Form) and I will forward the completed form to Medical Records Director of Crosswinds or my clinician. (KAR 30-60-47(b)(7), AAPS guidelines, Chapter 7, 1.a. (7), and 42 C.F.R. Part 2 Regulations)
- I understand that under state and federal confidentiality provisions, only the information specified can be released to only the specified person or agency. (42 C.F.R. Part 2 Regulations, KAR 30-60-47(b)(5), AAPS Guidelines, Chapter 7)
- The persons or organizations receiving any disclosure of the information referenced herein will generally be prohibited by law from re-disclosing any information received based upon this consent and will be notified of that fact in every health informational exchange disclosure. I understand that if the person or organization authorized to receive this information is not a health care provider, 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. (42 C.F.R. Part 2 Regulations)
- **I understand that this authorization will expire 1 year from the signature date or immediately upon revocation.**
- I understand that this authorization waives the community mental health center-patient privilege described in K.S.A. 65-5601 *et seq*.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I verify that this authorization is voluntary; and that I have asked and received answers to my questions.

Client Signature _____ Date _____

Parent/Guardian/Legal Rep. Signature _____ Printed Name _____ Date _____ Relationship to Client _____

*(Complete the following information **if address is DIFFERENT** from Client)*

Address _____ City _____ State _____ Zip Code _____

Telephone # _____

*Witness Signature _____ Date _____

"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."

Signature Page