Please select action needed:

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

CROSSWINDS COUNSELING & WELLNESS

1519 Merchant St. Emporia, KS 66801 Phone: 620 343-2211 Fax: 620 342-1021

Authorization for the Disclosure of Protected Health Information

Including Mental Health Information and/or Alcohol and Drug Records

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

I, the undersigned (client or Legal Representative) hereby authorize **CrossWinds Counseling & Wellness** to:
(Initial next to checked box if not typed)

RELEASE the following information:

If relevant, the following may contain substance use information.

_____ ☐ Intake/Admission Evaluation
_____ ☐ Discharge Summary
_____ ☐ Diagnosis Summary
_____ ☐ Treatment Plan(s)
_____ ☐ Medication List
_____ ☐ Lab Results
_____ ☐ Medical Reports
_____ ☐ Progress Notes
_____ ☐ Appointments/Scheduling/Attendance
_____ ☐ Emergency Contact Records

Substance Use Disorder (Alcohol/Drug) Information

_____ ☐ Substance Use Admission Evaluation (ASAM)
_____ ☐ Substance Use Appointments/Scheduling/Attendance
_____ ☐ Substance Use Progress Notes
_____ ☐ Substance Use Progress Review/Summary
_____ ☐ Substance Use Treatment Plan(s)
_____ ☐ Substance Use Diagnosis Summary
_____ ☐ UDS (Urine Drug Screen)
_____ ☐ Other:

OBTAIN the following information:

_____ ☐ Intake/Admission Evaluation
_____ ☐ Discharge Summary
_____ ☐ Diagnosis Summary
_____ ☐ Treatment Plan(s)
_____ ☐ Medication List
_____ ☐ Lab Results/Medical Reports/Psychiatric Evaluation
_____ ☐ Progress Notes
_____ ☐ Appointments/Scheduling/Attendance
_____ ☐ Emergency Contact Records
_____ ☐ Psychological Evaluation/Report
_____ ☐ Education Reports
_____ ☐ Employment Performance Report

Substance Use Disorder (Alcohol/Drug) Information

_____ ☐ Substance Use Admission Evaluation (ASAM)
_____ ☐ Substance Use Appointments/Scheduling/Attendance
_____ ☐ Substance Use Progress Notes
_____ ☐ Substance Use Progress Review/Summary
_____ ☐ Substance Use Treatment Plan(s)
_____ ☐ Substance Use Diagnosis Summary
_____ ☐ UDS (Urine Drug Screen)
_____ ☐ Other:

The information may be released to/obtained from:

Name/Agency:		Relationship/Specific Staff:	
Address:		City/State/Zip:	
Telephone #:		Fax #:	

Purpose or Need for Disclosure: (please review and select below)

☐ Treatment Coordination ☐ Legal (Court/Attorney/CRB) ☐ Scheduling ☐ Transfer Treatment Provider

☐ Involve Family in Treatment ☐ Testify or Participate in Court Proceedings ☐ Other:

VERBAL COMMUNICATION (Initial next to checked box if not pre-typed)

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

DISCLOSURE LIMITATIONS: (ex: Insurance, Substance Use, etc.) 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)
- I understand that certain records may be protected by federal or state law, including communicable diseases, and I am consenting that any and all such protected records be released under this authorization.
- 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 unless I revoke this authorization, it will automatically expire 1 year from my signature or the following specific date (not to exceed 1 year) or event:** _____ (answer if expire by event)
- 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/Legal Guardian Signature	Printed Name	Date	Relationship to Client

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

Address	City	State	Zip Code

Telephone #

Crosswinds Printed/Typed Name ☐ Witnessed ☐ Received — 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."