

<input type="checkbox"/>	Send Records
<input type="checkbox"/>	Request Info
<input type="checkbox"/>	Service Letter
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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)

<p>RELEASE the following information:</p> <p><i>If relevant, the following may contain substance use information.</i></p> <p><input type="checkbox"/> Intake/ Admission Evaluation</p> <p><input type="checkbox"/> Discharge Summary</p> <p><input type="checkbox"/> Diagnosis Summary</p> <p><input type="checkbox"/> Treatment Plan(s)</p> <p><input type="checkbox"/> Medication List</p> <p><input type="checkbox"/> Lab Results</p> <p><input type="checkbox"/> Medical Reports</p> <p><input type="checkbox"/> Progress Notes</p> <p><input type="checkbox"/> Appointments/Scheduling/ Attendance</p> <p><input type="checkbox"/> Emergency Contact Records</p> <p>Substance Use Disorder (Alcohol/Drug) Information</p> <p><input type="checkbox"/> Substance Use Admission Evaluation</p> <p><input type="checkbox"/> Substance Use Appointments/Scheduling/Attendance</p> <p><input type="checkbox"/> Substance Use Progress Notes</p> <p><input type="checkbox"/> Substance Use Progress Review/Summary</p> <p><input type="checkbox"/> Substance Use Treatment Plan(s)</p> <p><input type="checkbox"/> Substance Use Diagnosis Summary</p> <p><input type="checkbox"/> Substance Use Screenings/Assessments</p> <p><input type="checkbox"/> Substance Use Discharge Summary</p> <p><input type="checkbox"/> UDS (Urine Drug Screen)</p> <p><input type="checkbox"/> Other: _____</p>	<p>OBTAIN the following information:</p> <p><input type="checkbox"/> Intake/ Admission Evaluation</p> <p><input type="checkbox"/> Discharge Summary</p> <p><input type="checkbox"/> Diagnosis Summary</p> <p><input type="checkbox"/> Treatment Plan(s)</p> <p><input type="checkbox"/> Medication List</p> <p><input type="checkbox"/> Lab Results/Medical Reports/Psychiatric Evaluation</p> <p><input type="checkbox"/> Progress Notes</p> <p><input type="checkbox"/> Appointments/Scheduling/ Attendance</p> <p><input type="checkbox"/> Emergency Contact Records</p> <p><input type="checkbox"/> Psychological Evaluation/Report</p> <p><input type="checkbox"/> Education Reports</p> <p><input type="checkbox"/> Employment Performance Report</p> <p>Substance Use Disorder (Alcohol/Drug) Information</p> <p><input type="checkbox"/> Substance Use Admission Evaluation</p> <p><input type="checkbox"/> Substance Use Appointments/Scheduling/Attendance</p> <p><input type="checkbox"/> Substance Use Progress Notes</p> <p><input type="checkbox"/> Substance Use Progress Review/Summary</p> <p><input type="checkbox"/> Substance Use Treatment Plan(s)</p> <p><input type="checkbox"/> Substance Use Diagnosis Summary</p> <p><input type="checkbox"/> Substance Use Screenings/Assessments</p> <p><input type="checkbox"/> Substance Use Discharge Summary</p> <p><input type="checkbox"/> UDS (Urine Drug Screen)</p> <p><input type="checkbox"/> Other: _____</p>
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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 expires 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.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Client/Legal Guardian Signature	Printed Name	Date	Relationship to Client

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	City	State	Zip Code

Telephone #

<input type="text"/>	<input type="text"/>
Crosswinds Printed/Typed Name <input type="checkbox"/> Witnessed <input type="checkbox"/> 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.”