Mental Health America of South Central Kansas

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A			
Consumer Last Name	First Name	MI	DOB
Parent/Guardian Name (Last, First)	Parent/Guardian Address (Street, City, Zip)		

Section B: I authorize Mental Health America of South Central Kansas (MHA), to release and request information as specified below from/to:		
Name	Address	Phone
Email	Fax	

The purpose of this disclosure is:
☐ Case Coordination ☐ Legal ☐ Medical ☐ Billing/Reimbursement ☐ Other _____

Verbal Communication (Please initial if applicable)
_____ I authorize verbal communication with the person or agency listed above to coordinate treatment, allow discussion of treatment progress. and discuss relevant concerns or issues regarding the above-named consumer's treatment.

RESTRICTIONS - The information indicated will be disclosed unless there are specific restrictions noted here:

Section C: Release the following information: (Please initial each applicable item)	Section D: Request the following information: (Please initial each applicable item)
_____ Account Information	_____ Account Information
_____ Admission Evaluation	_____ Admission Evaluation
_____ AIDS/HIV Information	_____ AIDS/HIV Information
_____ Appointment Information	_____ Appointment Information
_____ Billing/Reimbursement	_____ Billing/Reimbursement
_____ Consultation	_____ Consultation
_____ Diagnosis	_____ Diagnosis
_____ Diagnosis Evaluation	_____ Diagnosis Evaluation
_____ Discharge Information	_____ Discharge Information
_____ Durg and Alcohol Treatment Records	_____ Durg and Alcohol Treatment Records
_____ Education Evaluation	_____ Education Evaluation
_____ Electronic Information Exchange	_____ Electronic Information Exchange
_____ Emergency Information	_____ Emergency Information
_____ Employment Issues	_____ Employment Issues
_____ Lab Reports	_____ Lab Reports
_____ Legal Documents	_____ Legal Documents
_____ Medical Evaluation	_____ Medical Evaluation
_____ Medications	_____ Medications
_____ Progress Notes	_____ Progress Notes
_____ Psychiatric Evaluation	_____ Psychiatric Evaluation
_____ School Records	_____ School Records
_____ Tests	_____ Tests
_____ Treatment	_____ Treatment
_____ Treatment Plan	_____ Treatment Plan

THIS DOCUMENT IS NOT VALID UNLESS THE INFORMATION COMPLETE ON BOTH SIDES OF THIS FORM

identification may be required to complete this form.

A photostatic copy of this Authorization shall be considered as valid as the originate

Mental Health America of South Central Kansas

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

Section G: 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 will notify MHA. (KAR 30-60 47(b)(7), AAPS Standards for Licensure/Certification Chapter 7, 1 and CFR-42, part 2)

Section H: I understand this authorization will automatically expire 90 days after discharge or one year from the date of authorization whether comes first unless I indicate a specific date or event below

---

Section I: understand that if the person or organization authorized 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 J: I understand that this authorization is voluntary. and I verify that I have been given the chance to ask and receive answers to questions.

Section K: Signatures	
Signature of Consumer	Date
Signature of Authorized Representative (if applicable)	Date
Signature of Witness	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 them from making any further disclosures 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 effluent for this purpose.

THIS DOCUMENT IS NOT VALID UNLESS THE INFORMATION COMPLETE ON BOTH SIDES OF THIS FORM

identification may be required to complete this form.

A photostatic copy of this Authorization shall be considered as valid as the originate