
Marcia Kennedy, LSCSW, LCP 316-371-7226 654 N. Woodchuck, Suite F Wichita, KS 67212

Authorization for Release of Protected Health Information
Please fill in ALL blanks

Client's Full Name: _____ DOB: _____
Other Names Used:_____
Telephone Number: _____ SSN: _____
I, _____ authorize:

MKC-Counseling/MKC-Services
Marcia Kennedy, LSCSW, LCP
PO Box 75523_____
Wichita, KS 67275_____
316-371-7226_____
Email: Marcia@mkc-services.com

___X__ To Disclose to OR
___X__ Obtain from

Agency Name: _____
Provider Name (if applicable) _____
Email: _____
Phone: _____
Address (City, State, and Zip) _____

The information to be disclosed is:

| | |
|---|---|
| _____Discharge Summary | _____ Social History |
| _____Psychiatric Evaluation | _____ Progress Notes |
| _____Medical History & Physical | _____Medication Record |
| _____Lab Data/Reports | _____HIV/AIDS Information |
| _____Special Education Records | _____Court Orders/Reports |
| _____Psychological Evaluation | _____Case/Treatment Plan |
| _____Foster Care Licensing/MAPP info | _____Diagnosis/Prognosis |

__X___Other: adoption home studies, updates and fingerprint results
For the treatment dates of _____

I understand that my treatment/health information may contain information relating to: HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law and I authorize disclosure of that information. Any alcohol and/or drug treatment records are protected under federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be redisclosed by the person receiving it. I understand that I may refuse to sign this Authorization and that my treatment or payment for my treatment will not be affected if I do not sign this form unless my treatment includes

research or the reason for my treatment is to disclose information to another person. I understand that I may see and copy the information described on this form as provided by federal regulations, and that I will get a copy of this form after I sign it.

I understand that I can revoke this authorization in writing but that any revocation is not effective for disclosures that have already been made. To revoke authorization, I should contact: Marcia Kennedy Cordes, EdS, LMSW at the above listed contact information.

| | |
|---|---|
| _____ | _____ |
| Signature of Client/Date | Signature of Personal Representative of Client/Date |
| _____ | _____ |
| Signature of Witness/Date | Personal Representative's Relationship to Client |

*Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature