Release of Information

Client's Name: _____**DOB:**_____ **SS#:**_____

I authorize _____**Phone#:**_____ **to:**

☐ Disclose Information to the below individual/organization
☐ Obtain Information from the below individual/organization

Send requested information by:

☐ Fax:_____ ☐ Email: _____☐ Verbal ☐ Mail (see below)

Name/Organization: _____Phone#: _____

Address: _____City: _____ State: _____ Zip:_____

Purpose:

☐ Collaboration ☐ Continuity of Care ☐ Other _____

Information to Be Exchanged:

☐ Exchange of all information listed below
☐ Progress Notes
☐ Treatment Plan Summary
☐ Billing/Account Summary
☐ OTHER: _____

Statement of Understanding:

I understand that my signature authorizes the release of this information either written or verbally only between the above-named persons or agency. I understand that I may withdraw this authorization by written notice. I understand that this authorization will remain in effect for one year (365 days) from the date of the signature below, unless I specify an earlier date as indicated _____. I understand that I have the right to inspect this information prior to the release.

_____ _____ _____ _____
Signature of Client *(Age 13 and Above)* Date Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

RE-DISCLOSURE PROVISION:
Note to receiving agencies/person: Under provisions of the Kansas Mental Health and Developmental Disabilities Confidentiality Act, you may not re-disclose any of the information unless the person who consented to this disclosure specifically consents to such re-disclosure. Information released to said Agency will be confidential and will not be released to another party without the signed consent of the client and/or his parent/guardian.