



# AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

## Section A

Please Print Legibly

Client Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Name (Last, First) \* \_\_\_\_\_ Parent/Guardian Address (Street, City, Zip) \_\_\_\_\_ Parent/Guardian Phone # \_\_\_\_\_

## Section B

I authorize **PAWNEE MENTAL HEALTH SERVICES**, \_\_\_\_\_ to:  
 Pawnee office address

## Section C

**RELEASE** the following written information:  
 (Please initial each applicable item)

- \_\_\_\_\_ Admission Evaluation Report
- \_\_\_\_\_ Diagnosis
- \_\_\_\_\_ Treatment Plan(s)
- \_\_\_\_\_ Psychiatric Consultation Report
- \_\_\_\_\_ Psychological Evaluation Report
- \_\_\_\_\_ Discharge Summary
- \_\_\_\_\_ Progress Review(s)
- \_\_\_\_\_ Alcohol and Drug Treatment information
- (\* See Next Page.)
- \_\_\_\_\_ Hospitalization Screening
- \_\_\_\_\_ Progress Notes: FROM \_\_\_\_\_ TO \_\_\_\_\_
- \_\_\_\_\_ Medical \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_

## Section D

**OBTAIN** the following written information:  
 (Please initial each applicable item)

- \_\_\_\_\_ Admission Evaluation Report
- \_\_\_\_\_ Diagnosis
- \_\_\_\_\_ Treatment Plan(s)
- \_\_\_\_\_ Psychiatric Consultation Report
- \_\_\_\_\_ Psychological Evaluation Report
- \_\_\_\_\_ Discharge Summary
- \_\_\_\_\_ Progress Review(s)
- \_\_\_\_\_ Alcohol and Drug Treatment Information
- \_\_\_\_\_ Hospitalization Screening
- \_\_\_\_\_ Progress Notes: FROM: \_\_\_\_\_ TO: \_\_\_\_\_
- \_\_\_\_\_ Medical Reports \_\_\_\_\_
- \_\_\_\_\_ Legal Reports \_\_\_\_\_
- \_\_\_\_\_ Education Reports \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_

## Section E

**VERBAL COMMUNICATION** (Please initial if applicable)

\_\_\_\_\_ I authorize verbal communication with the person or agency listed below in order to coordinate treatment, allow discussion of treatment progress, and discuss relevant concerns or issues regarding the above-named client's treatment.

## Section F

**RESTRICTIONS** – The information indicated will be disclosed unless there are specific restrictions noted here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Section G

**TO / FROM – NAME / AGENCY** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE, ZIP:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**THIS DOCUMENT IS NOT VALID UNLESS THE INFORMATION IS COMPLETE ON REVERSE SIDE**

\* Identification may be required to complete this form.

**Section H**

<b>THE PURPOSE OR NEED FOR THE DISCLOSURE (Initial all that apply)</b>		
_____ Evaluation / Treatment Planning	_____ Case Coordination	_____ Legal Proceedings
_____ School Placement or Assessment	_____ Other _____	

- **Section I:** 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 J:** I also understand that PMHS cannot ensure that the recipient will maintain confidentiality of this information I have authorized to be released.
- **Section K:** 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 need to notify PMHS. (KAR 30-60-47(b)(7), AAPS Standards for Licensure/Certification, Chapter 7,1.a.(7), and CFR-42, part 2)
- **Section L:** I also understand that this authorization will expire (Select One \*\*): (KAR 30-60-47(b)(6), CFR-42, part 2)
  - One year from this date (i.e., date of signature below).
  - OR  On the following date: \_\_\_\_\_ (MM/DD/YY).
  - OR  Upon the following specific event: (Please describe.) \_\_\_\_\_

\*\* Note: If neither a specific date or a specific event is selected this Authorization will automatically expire 90 days after discharge or one year from the date of authorization whichever comes first.

- 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 M:** 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 N:** Signature of Client (required for minors receiving A/D treatment ages 14 and above) Date

\_\_\_\_\_  
 Signature of Authorized Representative (if applicable) Date **Section O:** Relationship to Client

\_\_\_\_\_  
**Section P:** Witness (to Signature) 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 the recipient from making any further disclosure 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 sufficient for this purpose.

PMHS USE ONLY: Action Requested:	Action Taken:
_____ Send Request Immediately	_____ (Date) Sent by _____
_____ File	_____ (Date) Filed by _____

**\*\* A photostatic copy of this Authorization shall be considered as valid as the original. \*\***