THE CENTER FOR COUNSELING & CONSULTATION

AUTHORIZATION TO DISCLOSE/OBTAIN PROTECTED HEALTH INFORMATION

CLIENT INFORMATION

Last Name	First Name	Date of Birth	Social Security #
Address	City	State/Zip	Phone #

Name of Agency/Person: _____

Address: _____ Telephone #: _____ Fax #: _____

City, State, Zip: _____

I authorize: The Center for Counseling Telephone Number: **620-792-2544**

Address of Office: **5815 Broadway** Fax Number: **620-792-7052**

City, State, Zip: **Great Bend, KS 67530**

(check all that apply):

◯ **Release to** ◯ **Obtain from** ◯ **Discuss with**

The third party identified above specified protected information listed below for purposes of treatment, payment, health care, case coordination, and/or legal proceedings.

INITIAL ALL THAT APPLIES

	Intake/Admission Report		Presence in Program
	Psychiatric Evaluation Report		Discharge Summary/Report
	Case Plan/Treatment Plan		Hospital Screen
	Diagnosis/Prognosis		Medication Notes
	Psychological Evaluation Report & Recommendations		Medical/Physical History/Reports/Lab Results, X-Rays, Meds Prescribed
	Case Management Notes		Educational and/or Special Education Reports
	Therapy Progress Notes		HIV Testing, HIV Status, AIDS, TB or Hepatitis
	Alcohol and/or Drug Treatment Information, KCPC, Evaluation, Treatment Plan, Discharge Summary, Testing Results		Other:

I understand that my records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") 45 C.F.R. pts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time upon receipt of my written request except to the extent that action has been taken in reliance on it.

CHECK ONE THAT APPLIES

◯ Upon Discharge ◯ Specific Event (specify) _____ ◯ On the following date ___ - ___ - _____

I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization.

Signature of Patient/Legal Guardian: _____ Date: _____