AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
Johnson County Mental Health Center

☐ ACT	☐ Adult Detox Unit	☐ Shawnee Office	☐ Mission Office	☐ Olathe Office
301 N. Monroe	11120 W 65th Street	6440 Nieman	6000 Lamar Ste 130	1125 W. Spruce
Olathe, KS 66061	Shawnee, KS 66203	Shawnee, KS 66203	Mission, KS 66202	Olathe, KS 66061
913-782-0283	913-826-4100	913-826-4000	913-831-2550	913-715-7700
913-782-0609 (fax)	913-826-4101 (fax)	913-826-4993 (fax)	913-826-1534 (fax)	913-782-1186 (fax)

Name of Client _____ (Maiden Name, If Applicable) _____ Last 4 digits of SSN _____ DOB _____ JCMHC ID# _____

I hereby authorize **Johnson County Mental Health Center**: ☐ to release to **&/or** ☐ to receive from

_____
(name of agency, program, or individual; if an individual, identify relationship to client)

at _____
(address, phone and fax number, if available)

☐ Mental Health Treatment Records ☐ Substance Abuse Treatment Records checked below from the medical record of the client named above (one or both record types must be marked to be a valid authorization).

JCMHC to Release		**JCMHC to Receive:**	
☐ Acknowledgement of Treatment	☐ Treatment Review/Progress Rpt	☐ Acknowledgement of Treatment	☐ Treatment Review/Progress Rpt
☐ Billing &/or Insurance Info	☐ Psychological Eval/Report	☐ Billing &/or Insurance Info	☐ Psychological Eval/Report
☐ Intake/Admission Information	☐ Waiver Documents	☐ Intake/Admission Information	☐ Waiver Documents
☐ Diagnosis	☐ AAPS Eligibility Documents	☐ Diagnosis	☐ School Records/Reports/IEPs
☐ Treatment Plan/Plan of Care	☐ KCPC (Electronic Version)	☐ Treatment Plan/Plan of Care	☐ Immunization Records
☐ Psychiatric Evaluation	☐ Screening Assessment	☐ Psychiatric Evaluation	☐ KCPC (Electronic Version)
☐ Medications Prescribed	☐ Discharge Summary/Plan	☐ Medications Prescribed	☐ AAPS Eligibility Documents
☐ Medical History & Physical	☐ Other: _____	☐ Medical History & Physical	☐ Placement History
☐ Lab Results	☐ Other: _____	☐ Lab Results	☐ Discharge Summary /Plan
☐ Psychosocial Assessment	☐ Other: _____	☐ Psychosocial Assessment	☐ Other: _____
☐ Strengths Assessment	☐ Other: _____	☐ Strengths Assessment	☐ Other: _____
☐ Progress Notes		☐ Progress Notes	

I understand this information will be used for the following purpose(s):_____
or ☐ Records are requested by the client/guardian for his/her own use.

I understand that the treatment records may include medical, psychiatric, alcohol and drug abuse &/or HIV information. I understand that my records are protected by law and cannot be disclosed or re-disclosed without my consent. However, records released from JCMHC to a non- covered entity may be subject to re-disclosure and no longer protected. I understand that I am not required to authorize release of confidential information in order to receive treatment. I may revoke this consent, in writing, at any time except for information that has already been sent out. Unless I revoke it earlier, this consent will expire in ☐ 30 days, ☐ 60 days, ☐ 90 days, ☐ 180 days, or automatically one year after date of signature.

Signature of Client (age 14 or older) _____ Printed Name of Client _____ Date _____

Signature of Parent or Legal Guardian _____ Printed Name of Parent or Legal Guardian _____ Date _____

☐ **Client verbally revoked ROI on:** _____ **Staff Signature and Date:** _____
☐ **Authorization revoked by client or guardian by attached statement dated:** _____**; or,**
☐ **I hereby revoke the above authorization to release confidential information.**

Signature of Client (age 14 or older) _____ Signature of Parent or Legal Guardian _____ Date _____

Revocation Disclaimer Substance Abuse Services Only: **If my treatment was mandated by the court, this permission cannot be revoked until I am officially released from confinement, parole, or probation.**

Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of this information except with the specific written consent of the person to who it pertains. A general authorization for the release of medical information or other information if held by another party is not sufficient for this purpose.

Release: ☐ File Only ☐ Mail ☐ Fax ☐ Electronic
Receive: ☐ File Only ☐ Mail ☐ Fax ☐ Electronic
Staff Signature: _____

Medical Records Staff ONLY:

Date Sent:	_____	**by**	_____
Date Requested:	_____	**by**	_____
Date Entered in EHR:	_____	**by**	_____

5-2013