Wyandot Behavioral Health Network

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

1301 N. 47th St., Kansas City KS 66102 **Phone**:(913) 328 – 4689 **Fax**:(913) 563 – 6596 **Email**: wbhnmedicalrecords@wyandotbhn.org

Client Name: _____ **Chosen Name:** _____

Phone #: (_____) _____-_____ DOB: _____/_____/_____ Last 4 Digits of SSN: _____

***The Name of Facility/Individual Releasing Information To/Obtaining Information From:**

Facility: **Individual:** **Relationship:**

_____ _____ **(**_____**)**

Address, City/State/Zip: _____

Phone #: (_____) _____-_____ Fax #: (_____) _____-_____ Email: _____

***The Information to be Released (Client /Parent /Guardian /Representative Initial below all that apply):**

_____To Exchange Information with _____To Disclose Information to _____To Obtain Information from

_____Diagnostic Review _____Entire Medical Record _____Substance Use Disorder Diagnosis
_____Treatment Plan _____Progress in Treatment _____Substance Use Disorder Assessment
_____Medications _____Psychosocial Assessment _____Substance Use Disorder Treatment Plan
_____Intake Assessment _____School Records _____Substance Use Disorder Progress Notes
_____Psychiatric Evaluation _____Other (please specify): _____
_____**Verbal and/or Written Communication:** _____Progress Notes from: **(___/___/___) to (___/___/___)**
_____**Clinical** _____Financial _____Date range to be released: **(___/___/___) to (___/___/___)**

***The Purpose for the Disclosure (Client /Parent /Guardian /Representative Initial below all that apply):**

_____Evaluation _____Coordination of Care _____Legal Proceedings _____School Placement/Assessment

_____Other: _____

Expiration Date: **(_____/_____/_____)** This authorization (unless expressly revoked) will remain in effect until the designated expiration date or event **(not to exceed one year from the date of the signature).** I have the right to revoke this authorization, in writing at any time, except to the extent that Wyandot BHN Inc. has already taken action in the reliance on it. Only the information specified can be released to only the specified person/agency. Information used or disclosed under the Authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability Act Privacy Rule (45 C.F.R. Part 164) and the Privacy Act of 1974 (5 U.S.C. 552a). Wyandot BHN Inc. cannot ensure the recipient will maintain confidentiality of this information I have authorized to be released.

_____
Printed Name of Client /Parent /Guardian /Representative **(Relationship to Client)**

_____**(**_____/_____/_____**)**
Signature of Client /Parent /Guardian /Representative **Date**

_____**(**_____/_____/_____**)**
Signature of Witness **Date**

***Client /Parent /Guardian /Representative Initial: _____ I consent to my WBHN Provider to witness this document.**

***Client /Parent /Guardian /Representative Initial: _____ I consent to, and I acknowledge that sensitive information regarding alcohol/drug abuse treatment/referrals, sexually transmitted diseases; mental health information and/or HIV/AIDS related treatment or status could be included in your record and may be disclosed as a result of your execution of this authorization**.

NOTICE TO RECIPIENT: PROHIBITION ON REDISCLOSURE

*This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U. S. C. 290dd-3 and 42 U. S. C. 290ee-3 and Title 42 Code of Federal Regulations). Federal regulations (42 C.F.R. Part 2) prohibit you from making any further disclosure of these records without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. 42 C.F.R Part 2 restricts use of substance abuse information to criminally investigate or prosecute any alcohol or drug abuse patient.

For WBHN Internal Use, Please Check: **_____File _____Send Records _____Get Records**

_____ _____ **11/23**
Staff Requesting Records/Release of Records **Chart #**