Wyandot
Behavioral Health Network

1301 N 47th Street
Kansas City, Kansas 66102

Phone: (913) 328-4689
Fax: (913) 563-6596
Email: wbhnmedicalrecords@wyandotbhn.org

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client Information

Client Name:	
Chosen Name:	
Client ID:	
Date of Birth:	

Facility/Individual Releasing Information to/Obtaining Information From

Facility/Individual Name	Address	Phone Number	Fax Number	Email

Information to be Released

Select all that apply AND initial next to each item selected.

Exchange Information:

☐ Diagnostic Review Initials: _____
☐ Treatment Plan Initials: _____
☐ Medication(s) Initials: _____
☐ Intake Assessment Initials: _____
☐ Psychiatric Evaluation Initials: _____
☐ Verbal Communication Initials: _____

Disclose Information:

☐ Entire Record Initials: _____
☐ Progress in Treatment Initials: _____
☐ Psychosocial Assessment Initials: _____
☐ School Records Initials: _____
☐ Other: _____ Initials: _____
☐ Date Range: Initials: _____

- From: _____
- To: _____

Obtain Information:

☐ Substance Use Disorder Diagnosis Initials: _____
☐ Substance Use Disorder Assessment Initials: _____
☐ Substance Use Disorder Treatment Plan Initials: _____
☐ Substance Use Disorder Progress Notes Initials: _____

Purpose for the Disclosure

☐ Evaluation Initials: _____
☐ Coordination of Care Initials: _____
☐ Legal Initials: _____
☐ School Placement/Assessment Initials: _____
☐ Other: _____ Initials: _____

Signatures

Printed Name of Client/Parent/Guardian/Representative:

_____

Relationship to Client:

_____

Signature of Client/Parent/Guardian/Representative:

_____

Date:

_____

Signature of Youth (Required if age 14 or older)
If the client is 14 or older and receiving outpatient mental health services under K.S.A. 65-5602, the client's signature is required to authorize release of these records, even to a parent or legal guardian.
Signature:

_____

Date:

_____

Signature of Witness:

_____

Date:

_____

☐ I consent to my WBHN provider witnessing this document

Initials: _____

☐ 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 treatment or status could be included in your record and may be disclosed as a result of your execution of this authorization.

Initials: _____

Notice to Recipient: Prohibition of 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 the 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.

Internal Use Only

Select all that apply:

☐ File

☐ Send Records

☐ Get Records