

# PROTECTED HEALTH INFORMATION AUTHORIZATION

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

The undersigned hereby authorizes and requests Elizabeth Layton Center staff:

- To Release Information To:
- To Obtain Information From:
- To Exchange Verbal Information With:

Facility/Clinician: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

**THE FOLLOWING INFORMATION FROM MY CLINICAL RECORD:**

- \_\_\_\_\_ Medical Records; Summary of Assessment and Treatment,
- \_\_\_\_\_ Psychological Records, Treatment Summaries, Psychological Testing, etc.
- \_\_\_\_\_ Information Pertinent to **Chemical Dependency Evaluation/ADSAP Attendance**
- \_\_\_\_\_ Arresting officers narrative summary (AOR), BAC and relevant court documents
- \_\_\_\_\_ Information Pertinent to **Mental Status Functional Assessment**
- \_\_\_\_\_ Information Pertinent to **Income/Payment and Insurance Information**
- \_\_\_\_\_ Parenting Assessment
- \_\_\_\_\_ Other specific information: \_\_\_\_\_

**THE PURPOSE AND NEED FOR SUCH DISCLOSURE:**

- Continuity of Care
- Compliance with conditions set by court/attorney
- Compliance with conditions set by parole/probation
- Fulfill Request From Attorney
- Referral to Another Agency
- Other specific reason(s): \_\_\_\_\_

This consent to disclose information contained in my medical/clinical records may be revoked by me at any time, except to the extent that action has already been taken in reliance thereon. I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above. This consent, unless previously revoked, will expire 90 days past discharge of treatment at the Elizabeth Layton Center, Inc. or to expire on \_\_\_\_\_.

I understand that the information contained in my medical/clinical records contains confidential psychiatric information that may include drug and alcohol and HIV information. This information may be protected by Federal and State Law. I further understand that Elizabeth Layton Center., shall only release this information to the agency or person named above.

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Client (All clients 14 years of age and older must sign)\*If applicable:

\_\_\_\_\_  
Signature of parent, guardian, or legal representative      Printed Name of Representative      Specify Relationship      Date

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Witness

**PROHIBITION OF RE-DISCLOSURE:** This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it 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.

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|---|---|--|---|--|
| <input type="checkbox"/> 204 East 15 <sup>th</sup> Street<br>Ottawa, Kansas 66067<br>785.242.3780<br>785.242.6397 Fax | <input type="checkbox"/> 2537 Eisenhower Road<br>Ottawa, Kansas 66067<br>785.242.2183<br>785.242.1859 Fax | <input type="checkbox"/> 505 South Hospital Drive<br>Paola, Kansas 66071<br>913.557.9096<br>913.294.9247 Fax | <input type="checkbox"/> 401 North East Street<br>Paola, Kansas 66071<br>913.557.9096<br>913.294.4996 Fax | <input type="checkbox"/> 29875 West 339 <sup>th</sup> Street<br>Osawatomie, Kansas 66064<br>913.557.9096<br>913.755.6754 Fax |
|---|---|--|---|--|

(Client records are maintained at the location checked above.)