



Revoked:  Yes Date of Revocation: \_\_\_\_\_

### AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

\_\_\_\_\_  
Printed Name of Client                      Maiden Name (If Applicable)                      Last 4 digits of SSN                      DOB

I hereby authorize **Elizabeth Layton Center** to:     **Release to**                      and/or                       **Receive from**

**Individual/Agency** (if individual is listed, identify relationship to client): \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State & Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax (optional): \_\_\_\_\_

**The following information from my medical/clinical record may be released and/or obtained as checked (✓):**

<input type="checkbox"/> Medical/Records; Summary of Assessment & Treatment	<input type="checkbox"/> Appointment Information
<input type="checkbox"/> Psychological/Psychiatric Records; Summary of Assessment & Treatment	<input type="checkbox"/> Income, Payment & Insurance
<input type="checkbox"/> Substance Abuse Attendance, Summary of Assessment & Treatment	<input type="checkbox"/> HIV Testing or Treatment or Treatment of AIDS & AIDS-related conditions
<input type="checkbox"/> Arresting Officer's Narrative Summary (AOR), BAC and Related Court Documents	<input type="checkbox"/> Other-Specific Information _____

All records specified above may be requested or disclosed unless restrictions are specified here: \_\_\_\_\_

I understand that the information shared will be used for the purpose of:     Treatment                       Evaluation                       Coordination of Care  
 Disability Determination     Fulfill Request From Attorney                       Other – specify reason(s) \_\_\_\_\_

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above. This authorization to disclose information contained in my medical/clinical records may be revoked by me at any time by providing verbal or written notice, except for any information or record or portion of that record that has already been released. **Unless I revoke this authorization earlier, it will expire in:**     3 months     6 months     9 months or it will automatically expire one year after the date it is signed by the client/guardian.

I understand that I am not required to release confidential information in order to receive treatment. I understand that the information contained in my medical/clinical records contains (or may contain) confidential psychiatric information that may include drug, 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(s) named above. I also understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by Federal or State Privacy regulations, the information described above may be re-disclosed without my permission and no longer protected by those regulations.

X \_\_\_\_\_  
Signature of Client (age 14 or older)                      Date

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

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

**PROHIBITION OF RE-DISCLOSURE:** This information has been disclosed to you from records whose confidentiality is protected by law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general consent for the release of medical or other information is **NOT** sufficient for this purpose.

**Elizabeth Layton Center - Franklin County**  
Attn: Medical Records  
PO Box 677  
Ottawa, KS 66067  
(785) 242-3780 Office  
(785) 242-6397 Fax

**Elizabeth Layton Center - Miami County**  
Attn: Medical Records  
PO Box 463  
Paola, KS 66071  
(913) 557-9096 Office  
(913) 294-9247 Fax