**HORIZONS MENTAL HEALTH CENTER**

**1600 N Lorraine Suite 202, Hutchinson KS 67501 – P: 620-663-7595 – Fax: 620-513-5098**

## AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**PLEASE PRINT**

| _____ | _____ | _____ |
|---|---|---|
| ***Client Last Name*** | ***Client First Name*** | ***Client Date of Birth*** |
| _____ | _____ | _____ |
| Address | City, State, Zip | ***Phone Number*** |

**I, the client or legal representative, hereby authorize HORIZONS MENTAL HEALTH CENTER (HMHC) to:**

**RELEASE the following information:**

**Substance Use Disorder (SUD) Program**

- ☐ Any SUD (Alcohol/Drug) Information
  - ☐ SUD admission evaluation (KCPC)
  - ☐ SUD appointments/scheduling/attendance
  - ☐ SUD progress notes
  - ☐ SUD progress review/summary
  - ☐ SUD treatment plan(s)
  - ☐ SUD Labs

**Mental Health Record**

- ☐ Complete Legal Medical Record
- ☐ Information Relevant to an Emergency Situation
- ☐ Intake/Admission Evaluation
- ☐ Progress Notes
- ☐ Treatment Plan(s)
- ☐ Verbal progress updates/reviews
- ☐ Appointments/Scheduling/Attendance
- ☐ Lab Results
- ☐ Medical Reports/Psychiatric Evaluation
- ☐ Medication List
- ☐ Psychological Evaluation/Report
- ☐ Screenings (hospitalization)
- ☐ Discharge Summary
- ☐ Education Reports
- ☐ Legal Documents/Reports
- ☐ Billing Records
- ☐ Other: _____

**OBTAIN the following information:**

**Substance Use Disorder (SUD) Program**

- ☐ Any SUD (Alcohol/Drug) Information
  - ☐ SUD admission evaluation (KCPC)
  - ☐ SUD appointments/scheduling/attendance
  - ☐ SUD progress notes
  - ☐ SUD progress review/summary
  - ☐ SUD treatment plan(s)
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- ☐ Psychological Evaluation/Report
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- ☐ Discharge Summary
- ☐ Education Reports
- ☐ Legal Documents/Reports
- ☐ Billing Records
- ☐ Other: _____

***TO/FROM: Name/Agency*** _____

Address: _____ City, State, Zip: _____

***Phone Number:*** _____ ***Fax Number:*** _____

Purpose: ☐ Evaluation/Treatment Planning ☐ Case Coordination ☐ Payment ☐ Legal ☐ Scheduling
☐ School Placement/Assessment ☐ Emergency ☐ Other: _____

Restrictions (The information indicated will be disclosed unless there are specific restrictions noted here): ☐ Verbal Only
☐ Other: _____



Form #12 Created 6-28-18 (VLM) – Rev. 10/18 (VLM)-Revised 10/22 (KAM) ----- I:_Horizons/Forms/Approved Forms – ROI

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## AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

***THIS IS A TWO PAGE DOCUMENT – BOTH PAGES MUST BE COMPLETED FOR THE AUTHORIZATION TO BE VALID***

- I understand that under state and federal confidentiality provisions, only the information specified can be released to the specified person or agency (CFR42 part 2; KAR 30-60-47(b)(5)
- I understand that HMHC cannot ensure the recipient will maintain confidentiality of the information I have authorized to be released.
- I understand this authorization will be honored unless revoked verbally or in writing. Revocation may be made at any time except to the extent the action has already been taken. To revoke an authorization, I need to notify HMHC.
- I understand that if the person or organization authorized to receive this information is not a healthcare provider or health plan or is not otherwise covered under federal privacy regulations, the released information may be re-disclosed and will no longer be protected by federal privacy laws. I understand that certain persons or organizations may not re-disclose substance abuse treatment information.
- I understand the treatment records may include medical, psychiatric, substance use (alcohol/drug), and/or HIV (AIDS) information.
- I understand if I use a general designation regarding to whom my substance use disorder information may be disclosed, I have a right to receive a list of the entities the information was disclosed to.
- I understand this authorization is voluntary and I verify I have been given the chance to ask and receive answers to questions. I understand my treatment will not be conditioned upon signing this authorization.

I understand that unless I revoke it earlier, this authorization will automatically expire one year from the date of signature unless otherwise specified. (Specific date or event may not exceed one year)

***Specific date or event:*** _____

_____ _____ _____
***Client Signature*** ***Printed Name*** ***Date***

_____ _____ _____
***Authorized Representative Signature*** ***Printed Name*** ***Date***

_____
***Relationship to Client***

*Complete the following information if address is **DIFFERENT** from Client:*

_____ _____
Authorized Representative Address, City, State, Zip Phone number

_____ _____
Witness Date

This information has been disclosed to you from records in which confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit the recipient from making any further disclosure of it without the specific written consent of the person to whom it pertains or except as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.