

Office Use ONLY

Immediate Action Needed: File Only Request Records Request Sent Staff Signature

Name of Client _____ (Maiden Name, if applicable) _____ Last 4 digits of SSN _____ DOB _____ JCMHC ID _____

I hereby authorize **Johnson County Mental Health Center:** to disclose to _____ AND/ OR to receive from _____

_____ (agency, program, or individual, if an individual, identify relationship to client)

Address _____ City/State _____ Zip Code _____

Phone _____ Fax Number _____ Email _____

Type of records authorized to be disclosed, one or both record types must be marked to be a valid authorization Mental Health and/or Substance Abuse

JCMHC to Disclose (mark each that apply)

JCMHC to Receive (mark each that apply)

- Acknowledgement of Treatment
- Billing and/or Insurance Info
- Diagnosis
- Discharge Summary / Plan
- Intake / Admission Information
- KCPC (Electronic Version ONLY)
- Labs
- Med/Psych Notes (date range) _____ / ____ / ____ to ____ / ____ / ____
- Medications Prescribed
- Other: _____
- Other: _____
- Plan of Care / Treatment Plan
- Progress Notes (date range) _____ / ____ / ____ to ____ / ____ / ____
- Progress Summary (letters)
- Psychiatric Eval/Reports
- Psychological Eval/Reports
- TB Results
- UA

- Acknowledgement of Treatment
- Billing and/or Insurance Info
- Child Welfare Placement
- Diagnosis
- Discharge Summary / Plan
- Immunization
- Intake / Admission Information
- KCPC (Electronic Version ONLY)
- Labs
- Med/Psych Notes (date range) _____ / ____ / ____ to ____ / ____ / ____
- Medical History
- Medications Prescribed
- Other: _____
- Plan of Care / Treatment Plan
- Progress Notes (date range) _____ / ____ / ____ to ____ / ____ / ____
- Progress Summary (letters)
- Psychiatric Eval/Reports
- Psychological Eval/Reports
- School Report/IEP/504
- TB Results
- UA
- Waiver Documents

I understand this information will be used for **the following purpose(s):**

- Coordinating Client Care/Treatment**
- Coordinating Client Care and Billing/Reimbursement**
- Court Testimony (Subpoena Required)**
- Emergency Contact**
- Records are Requested by the Client/Guardian for Personal Use**
- Other:** _____

*I understand that the healthcare information may include medical, psychiatric, alcohol and drug abuse, diagnosis or treatment &/or HIV information. Unless otherwise specified, health care records within the last six months of services will be disclosed. I understand that my records are protected by law and cannot be disclosed or re-disclosed without my consent. However, records disclosed from Johnson County Mental Health Center to a non-covered entity may be subject to re-disclosure and no longer protected. I understand that I am not required to authorize the disclosure of my protected healthcare information to receive treatment. I may request a copy of this authorization and the information disclosed. I may revoke this authorization, in writing, at any time with the exception of situations in which Johnson County Mental Health Center has taken action in reliance on the authorization. A photo or electronic copy of this authorization is considered as valid as the original. By signing this authorization I acknowledge I have read and understand the disclosures I have authorized and I have the legal right and authority to sign this document. **Unless I revoke it earlier, this consent will expire in 365 days, or other length of time indicated.***

30 Days 60 Days 90 Days 180 Days

Signature of Client (age 14 or older) _____ Printed Name of Client _____ Date Signed _____

Signature of Parent or Legal Guardian _____ Printed Name of Parent or Legal Guardian _____ Date Signed _____

Client/Guardian may revoke the ROI verbally, by written statement or using the Revocation of Release of Information form. Revocation form and full policy is on our website: jocogov.org/mentalhealth or at any of our locations.

Revocation Disclaimer Substance Abuse Services Only: **If my treatment was ordered by the court, this permission cannot be revoked until I am officially released from confinement, parole, or probation

Prohibition on Redislosure: This information has been disclosed to you from records whose confidentiality is protected by law. 42 CFR Part 2 and other state and federal laws prohibits unauthorized disclosure of these records.