Behavioral Health
Release of Information

PRAIRIE STAR Health Center
non-profit • FQHC

RELEASE OF INFORMATION

PATIENT INFORMATION			
LAST NAME	FIRST		MIDDLE
ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE		DATE OF BIRTH

PERSON(S) OR FACILITY TO *SEND* INFORMATION			PERSON(S) OR FACILITY TO *RECEIVE* INFORMATION		
NAME			NAME		
ADDRESS			ADDRESS		
CITY	ST	ZIP	CITY	ST	ZIP
PHONE	FAX		PHONE	FAX	

THIS INFORMATION WILL BE USED FOR: (please check all that apply

- ☐ **In Case of Emergency**
- ☐ **Case Coordination**
- ☐ **Legal Proceedings**
- ☐ **School Placement or Assessment**
- ☐ **Include Family in Treatment**
- ☐ **Scheduling**
- ☐ **Evaluation**
- ☐ **Treatment Planning**
- ☐ **Billing & Authorization for Treatment**
- ☐ **Other (please explain):** _____

INFORMATION TO BE DISCLOSED
(Please Check Each Applicable Item)

PSHC **RELEASE** the following information	PSHC **OBTAIN** the following information
☐ **Admission Evaluation Report**	☐ **Admission Evaluation Report**
☐ **Diagnosis**	☐ **Diagnosis**
☐ **Treatment Plan(s)**	☐ **Treatment Plan(s)**
☐ **Psychiatric Consultation Report**	☐ **Psychiatric Consultation Report**
☐ **Psychological Evaluation Report**	☐ **Psychological Evaluation Report**
☐ **Discharge Summary**	☐ **Discharge Summary**
☐ **Progress Review(s)**	☐ **Progress Review(s)**
☐ **Alcohol & Drug Assessment**	☐ **Alcohol & Drug Assessment**
☐ **Hospitalization Screening**	☐ **Hospitalization Screening**
☐ **Progress Notes: FROM: TO:**	☐ **Progress Notes: FROM: TO:**
☐ **Medical Reports**	☐ **Medical Reports**
☐ **Appointments & Scheduling**	☐ **Appointments & Scheduling**
☐ **Substance Abuse Testing** (Results ONLY will be released)	☐ **Substance Abuse Testing** (Results ONLY will be released)
☐ **Other (must specify):** _____	☐ **Other (must specify):** _____

METHOD OF DISCLOSURE

- ☐ **Mail**
- ☐ **Verbal**
- ☐ **email**
- ☐ **Fax (list fax #):**

RESTRICTIONS/INSTRUCTIONS

The information indicated will be disclosed unless specific restrictions are noted here:

_____

_____

_____

(OVER) ➡

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PLEASE INITIAL ALL LINES BELOW

_____ **I understand that under state and federal confidentiality provisions, only the information specified can be released to the specified person or agency.** *(CFR-42, part 2, KAR 30-60-47(b)(5), AAPS guidelines, Chapter 7)*

_____ **I understand that PSHC cannot ensure that the recipient will maintain confidentiality of the information I have authorized to be released.**

_____ **I understand that this authorization will be honored unless revoked verbally or in writing. Revocation may be made at any time except to the extent that action has already been taken. To revoke an authorization, I need to notify PSHC.** *(KAR 30-60-47(b)(7), AAPS Standards for Licensure/Certification, Chapter 7, 1.a.(7); CFR-42, part 2)*

_____ **I understand that if the person or organization authorized to receive this information is not a health care provider or a health plan, or is not otherwise covered under the 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.** *(CFR-42, part 2)*

_____ **I understand that this authorization is voluntary, and I verify that I have been given the chance to ask and receive answers to questions. I understand that my treatment will not be conditioned upon signing this authorization.**

_____ **I understand that this authorization will expire one (1) year from the date of this form.** *(KAR 30-60-47(b)(6), CFR-42, part 2)*

OR

_____ **I understand that this authorization will expire upon the following specific date or event. (Not to exceed one (1) year). Please describe:**

_____

_____

_____

NOTE: If neither a specific date nor a specific event is noted, this authorization will automatically expire one (1) year from the date of signature below.

PATIENT PRINTED NAME	PATIENT SIGNATURE	DATE
AUTHORIZED REPRESENTATIVE PRINTED NAME	AUTHORIZED REPRESENTATIVE SIGNATURE	DATE
RELATIONSHIP TO PATIENT	AUTHORIZED REPRESENTATIVE TELEPHONE NUMBER	
AUTHORIZED REPRESENTATIVE ADDRESS (STREET ADDRESS, CITY, ST, ZIP)		
WITNESS SIGNATURE		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.

A photocopy of this authorization shall be considered as valid as the original.