Revoked: ☐ **Yes; Date:**

COMCARE of Sedgwick County
Authorization for Requesting and Disclosing Protected Health Information

Name:	Date of Birth:	Social Security #:

I hereby authorize COMCARE of Sedgwick County to:

☐ Disclose information to ☐ Request information from ☐ exchange information with (obtain and/or disclose)

Name (include relationship to patient if a person is listed):
Address:
City: State: Zip Code:
Phone (optional): Fax (optional):

Check specific information being authorized to be released or obtained:

- ☐ Admission Intake
- ☐ Discharge Summary
- ☐ Psychological Evaluation Report
- ☐ Psychiatric Evaluation Report
- ☐ Substance Abuse Evaluation Report
- ☐ Presence in Program
- ☐ Completed External Forms (identify specific form):
- ☐ Other: _____
- ☐ Medical History, Lab results
- ☐ Diagnosis
- ☐ Treatment Plan
- ☐ Summary of Treatment
- ☐ Progress Notes
- ☐ Verbal or written progress reports/consultation

All of the records authorized above may be requested or disclosed unless restrictions are specified here:

_____

I understand that this information will be used for the purpose of:

☐ Evaluation ☐ Treatment ☐ Case Coordination ☐ Follow-up care
☐ Other (specify): _____

This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified PHI expires, but not later than one year from date listed below. ** **If this item is left blank, the authorization shall remain effective for 365 days after the date listed below.**

I, the undersigned, have read the above and authorized the request or disclosure of Protected Heath Information (PHI) as described.

I understand that treatment is not conditioned upon the execution of this authorization.

I understand that COMCARE of Sedgwick County cannot assure that the recipient will maintain confidentiality of this information you have authorized to be released.

I understand COMCARE of Sedgwick County may charge fees to provide copies of records and will apply guidelines and fee schedules established for compliance with the Kansas Open Records Act for this purpose.

I understand that I may revoke this authorization at any time by providing verbal or written notice to my treatment provider except to the extent that action has been taken in reliance on the authorization or as otherwise stated in Sedgwick County's "Notice of Privacy Practices".

Signature of Client/Legal Guardian	**Signature of Witness for External Entities**
Printed Name of Legal Guardian and Relationship	**Date**

For Internal COMCARE releases, the electronic staff signature serves as the Witness signature

(42 C.F.R. Part 2: Prohibition of Redisclosure: The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. 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).

COMCARE OF SEDGWICK COUNTY
Attn: Medical Records
1929 W. 21st St., Wichita, KS 67203

Patient Name: , Patient ID: