

Revoked: Yes; Date:

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

Name:	Date of Birth:	Social Security #:
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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:

- | | |
|---|--|
| <input type="checkbox"/> Admission Intake
<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Psychological Evaluation Report
<input type="checkbox"/> Psychiatric Evaluation Report
<input type="checkbox"/> Substance Abuse Evaluation Report
<input type="checkbox"/> Presence in Program
<input type="checkbox"/> Completed External Forms (identify specific form): _____
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Medical History, Lab results
<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Summary of Treatment
<input type="checkbox"/> Progress Notes
<input type="checkbox"/> 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 Health 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/Personal Representative	Signature of Witness for External Entities
Printed Name of Legal Guardian and Relationship	Date

****The electronic staff signature serves as the Witness signature.****

(42 C.F.R. Part 2: Prohibition of Rediscovery: 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
271 W. 3rd St N., Suite 600 Wichita, KS 67202

Patient Name: _____,

Patient ID: _____