

ANDREWS & ASSOCIATES
COUNSELING



Release of Information

Client's Name: _____ DOB: _____ SS#: _____

I authorize _____ Phone#: _____ to:

- Disclose Information to the below individual/organization
- Obtain Information from the below individual/organization

Send requested information by:

Fax: _____ Email: _____ Verbal Mail (see below)

Name/Organization: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

Purpose:

Collaboration Continuity of Care Other _____

Information to Be Exchanged:

- Exchange of all information listed below
- Progress Notes
- Treatment Plan Summary
- Billing/Account Summary
- OTHER: _____

Statement of Understanding:

I understand that my signature authorizes the release of this information either written or verbally only between the above-named persons or agency. I understand that I may withdraw this authorization by written notice. I understand that this authorization will remain in effect for one year (365 days) from the date of the signature below, unless I specify an earlier date as indicated _____. I understand that I have the right to inspect this information prior to the release.

Signature of Client
(Age 13 and Above) Date

Signature of Parent/Guardian Date

Signature of Witness Date

RE-DISCLOSURE PROVISION:
Note to receiving agencies/person: Under provisions of the Kansas Mental Health and Developmental Disabilities Confidentiality Act, you may not re-disclose any of the information unless the person who consented to this disclosure specifically consents to such re-disclosure. Information released to said Agency will be confidential and will not be released to another party without the signed consent of the client and/or his parent/guardian.