

AREA MENTAL HEALTH CENTER

RELEASE FOR EXCHANGE OF INFORMATION

This authorizes the following person or organization to release the following information to the Area Mental Health Center and the Area Mental Health Center to release to the following person or organization the following information:

(Name of person or organization)

The information to be released by Area Mental Health Center:

_____ History
_____ Diagnosis
_____ Summary of Treatment
_____ Medications
_____ Lab Work
_____ Psychological Testing
_____ Psychiatric Evaluation
_____ Alcohol/Drug Evaluation
_____ Substance Abuse TX
_____ HIV/AIDS Status (other communicable disease)
_____ Treatment Plan
_____ communication

The information to be released to the Area Mental Health Center:

_____ History
_____ Diagnosis
_____ Summary of Treatment
_____ Medications
_____ Lab Work
_____ Psychological Testing
_____ Psychiatric Evaluation
_____ Alcohol/Drug Evaluation
_____ Substance Abuse TX
_____ HIV/AIDS Status (other communicable disease)
_____ Other (Specify) communication

and is to be released or obtained for the purpose of communication - written/oral including copies of records

Except for purposes of collection of revenues for professional services rendered, this consent to release is valid for **one (1) year** or until otherwise specified and thereafter is invalid.

Specify date, event or condition that permit will expire.

You are advised that at any time between the time of signing and the expiration date listed above, you have the right to revoke this consent, by making this request verbally and/or to write your request to AMHC.

I understand that said information disclosed may contain psychiatric (K.S.A. 59-2946), substance abuse (42 C.F.R. Part 2) and/or HIV/AIDS (or other communicable disease K.S.A. 65-6001, -6004, -6008, -6009, -6016 and 60-427) information. I understand that my records are protected under the Federal and State confidentiality regulations and cannot be released without my written consent unless otherwise provided for in said regulations.

Patient's Name (Maiden or Former Name)

Date of Birth

Address

Witness

Date

Client/Patient Signature
(Age 18 years and over)

Date

Position

Signature of Responsible Party,
Parent, Guardian if under age 18

Date

Relationship to Client

Print Name of Parent or Responsible Party if under age 18

Patient's or Authorized Person's Signature for Authorization of Payment

(I authorized the payment of medical benefits to the physician or supplier for the services described on the attached claim.)

Please send information to the following address:

Area Mental Health Center
Garden City Business Office
1145 Kansas Plaza
Garden City, Kansas 67846