THE BERT NASH COMMUNITY MENTAL HEALTH CENTER, INC. (BNC)
200 Maine Street, Suite A, Lawrence, KS 66044 785-843-9192 Secure Fax 888-972-5022

Authorization for Release of Protected Health Information

The undersigned hereby consent to and authorize BNC to, as indicated, the authorized information pertaining to:

Client Name: _____ DOB: _____ SSN: _____

Address : _____ Phone: _____ ☐check if cell phone

_____ Email: _____

☐ **obtain records from:** ☐ **release records to:** ☐ **exchange oral information with:**

_____, _____,
"Staff" or Name of Person — Name of Facility/Organization or Relationship to Client

_____, _____, _____, _____,
Address — City — State — Zip

_____ _____ Email address _____
Fax Number — Telephone ☐check if cell phone — ☐ **E-mail/text Consent** BNC may correspond by e-mail/text as indicated below.

BNC to Obtain	BNC to Release		BNC to Obtain	BNC to Release	
☐	☐	Presence in treatment. (including dates of service)	☐	☐	Medical history and physical examination.
☐	☐	Intake evaluation, including substance use	☐	☐	Medication Record
☐	☐	Treatment Plan	☐	☐	Physician's orders
☐	☐	Diagnosis, brief description of progress and prognosis	☐	☐	Lab, EKG
☐	☐	Psychological tests or projective assessments	☐	☐	Medical discharge summary
☐	☐	**Progress Notes, including therapy notes**	☐	☐	Crisis Screening report
☐	☐	Legal Information (including police reports)	☐	☐	Custody Evaluation
☐	☐	Evaluations	☐	☐	Educational records including achievements and assessments. (IEP information, discipline records, school attendance.)
☐	☐	**Substance abuse information**			
☐	☐	**Scheduling**			
☐	☐	**Billing/Financial**	☐	☐	HIV/AIDS status
☐	☐	Other:_____.			

Information is Needed for the Following Purposes:

☐ To provide ongoing treatment/continuity of care.
☐ To provide educational services/ school placement or assessment/ coordination of services with authorized school officials
☐ Legal Proceedings
☐ Disability Determination
☐ To coordinate treatment efforts with my family/concerned person
☐ To coordinate treatment and continuing care efforts with my employer.
☐ To enable judges, attorneys, probation/parole officers to support treatment goals or make legal decisions on my behalf (Diversion, Probation, Parole)
☐ Other:_____.

READ CAREFULLY: I understand that my medical/behavioral health records are confidential and that the BNC cannot condition treatment based on the willingness or refusal to sign authorizations. I further understand that by signing this authorization, I am allowing: Release of information to the agency or person specified above including any drug and/or alcohol information if checked above (Drug and/or alcohol abuse information records are specifically protected by federal regulations) (42CFR Part 2). Federal Regulations prohibit the recipient of the information from making further disclosure without the specific, written consent of the responsible person, or as otherwise permitted by law or regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. In the event that the person/entity who receives this information is not covered by the federal privacy regulations the information described above may be re-disclosed and no longer protected by the federal regulations. This consent may be revoked by me at any time upon my written request to BNC Health Information Manager except to the extent that action has already been taken. **This authorization will expire on _____. If left blank, this authorization automatically expires 90 days after discharge**. This authorization to release information is subject to the following restrictions:_____.

*My signature below acknowledges that I have read and received a copy of BNC E-mail/Text Consent Notification.

_____ _____
*Client or Client's Parent/Legal Guardian Signature — Date

_____ _____
Printed Name — Relationship to client (if other than self)

_____ _____ _____
Signature of Witness — Printed Name — Date

Directions for Medical Records: ☐Request records ☐Send BNC records ☐Send release only ☐File in BNC Chart ☐Sent_____

Client ID: _____ **Client Name :** _____