FAMILY SERVICE & GUIDANCE CENTER

Authorization for Use and Disclosure of Protected Health Information

_____ Process Release
_____ Process Obtain
_____ File

Client Last Name	Client First Name	MI	DOB	SSN

I authorize Family Service and Guidance Center, Inc. to release or obtain the following written documents via: ____ Mail ____Electronic (Email) _____Fax ____Other: _____

Release Obtain (Please check each applicable entry)

- ☐ ☐ Admission Evaluation Report
- ☐ ☐ Diagnosis Only Report
- ☐ ☐ Treatment Plan(s) Report
- ☐ ☐ Psychiatric Consultation Report
- ☐ ☐ Psychological Evaluation Report
- ☐ ☐ Discharge Summary Report
- ☐ ☐ Medical Report
- ☐ ☐ Hospitalization Screening Report
- ☐ ☐ Progress Review(s) Report
- ☐ NA Learning Disorder Reports

Release Obtain (Please check each applicable entry)

- ☐ ☐ Progress Notes

Type: _____ Date Range: _____ _____

Type: _____ Date Range: _____ _____

Type: _____ Date Range: _____ _____

- ☐ ☐ Alcohol and Drug Information
- ☐ ☐ Other: _____
- ☐ ☐ Other: _____
- ☐ ☐ Other: _____

NA ☐ ____IEP, ____Grades, ____Attendance

☐ **FSGC Clinical Contact Information to School**

COMMUNICATION

I authorize the following form(s) of communication in order to coordinate treatment, allow discussion of treatment progress, and discuss relevant concerns or issues regarding client's treatment including diagnosis.

(Please initial if applicable and provide information below)

_____ Mail (Letter) **_____ Electronic (Email)** **_____ Verbal (Face/Face or telephone)**

RESTRICTIONS REQUESTED Regarding the Release of Written Documents Above OR Communication?

☐ NO ☐ YES – See Request to Restrict Uses and Disclosures of Protected Health Information Form

TO / FROM - NAME / AGENCY:_____

If above is a Name and not an Agency, What is the Relationship to the client?_____

ADDRESS: _____

CITY, STATE, ZIP: _____

EMAIL ADDRESS: _____ **FAX #:** _____

THE PURPOSE OR NEED FOR THE DISCLOSURE (Initial all that apply)

_____ Evaluation / Treatment Planning **_____ Case Coordination** **_____Legal Proceedings**

_____School Placement **_____Other_____**

EXPIRATION OF THE DISCLOSURE - I understand that this release will expire (Select One "X"):

___90 Days Post Discharge

___ On the following date: _____ (MM/DD/YY)

___ Upon the following specific event, (Please describe.) _____
I understand that it is my responsibility to inform the FSGC Medical Records Clerk when the noted event is past.

- I understand that under state and federal confidentiality provisions only the information specified can be released to the specified person or agency. (CFR – 42, part 2, KAR 30-60-47(b) (5), AAPS guidelines, Chapter 7)
- I understand that FSGC cannot ensure that the recipient will maintain confidentiality of this information I have authorized to be released.
- I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of the authorization.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations**.**
- I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing written notice of revocation to **FSGC.**
- I understand that Protected Health Information provided on portable electronic media will not be encrypted and may be at risk for inadvertent disclosure if lost or stolen. By requesting the use of portable electronic media, I accept this risk.
- I understand that fees may be charged for preparing and sending copies of records.

_____

Client Signature if at Least 14 Years of Age **Date**

_____ _____

Parent / Legal Guardian Printed Name **Relationship to Client** **Parent / Legal Guardian Signature**

I have reviewed this document with the Client and/or Legal Guardian and have answered all questions asked of me to the best of my knowledge.

_____ _____

Date **FSGC or Agency Staff Witness to Signature**

ROI.cw.0602/0803/0309/0909/1111/0113/ 0313/0613/1013.0715.0815.0916.092716