

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions: All of the blocks (1-6) *must* be completed.

If any block is *not* completed, then this "Authorization" form will be considered incomplete and cannot be used.

Please print all information except for required signatures.

Block 1 – Identification of Patient/Participant

Patient/Participant Name: _____ Date of Birth _____

Patient/Participant Address: _____

Street [Apt. Number, P.O. Box as applicable]. _____ City _____ State _____ Zip Code _____

Block 2 – Type of Records/Information to be Disclosed (*check only the following boxes, A or B*) if neither box is checked, or if both boxes are checked, this form will be considered defective and cannot be used. **If you want both types of records disclosed, you must use two separate forms, one for each purpose.**

(A) **Records except for Psychotherapy Notes** (B) **Psychotherapy Notes Only**

Describe what specific records you want disclosed – check as many as apply:

- | | | | |
|--|---|--|---|
| <input checked="" type="checkbox"/> Diagnosis | <input checked="" type="checkbox"/> Lab Results | <input checked="" type="checkbox"/> License Status | <input checked="" type="checkbox"/> Discharge/transfer Summary |
| <input checked="" type="checkbox"/> Medical History | <input checked="" type="checkbox"/> Physical Exam | <input checked="" type="checkbox"/> Assessments | <input checked="" type="checkbox"/> Re-release this same information from treatment programs I have attended or currently attending for monitoring/reporting purposes |
| <input checked="" type="checkbox"/> Treatment Provided | <input checked="" type="checkbox"/> Participation | <input checked="" type="checkbox"/> Aftercare Plan | <input checked="" type="checkbox"/> Kansas State Board of Nursing |
| <input checked="" type="checkbox"/> Psychological Evaluation | <input checked="" type="checkbox"/> Cooperation & Progress | <input checked="" type="checkbox"/> Family Assessment & Recommendation | |
| <input checked="" type="checkbox"/> Consultation Report | <input checked="" type="checkbox"/> Work Performance / Status | <input checked="" type="checkbox"/> Treatment Plan | |
| <input type="checkbox"/> Other: _____ | | | |

Block 3 – Heart of America Professional Network and its representatives may disclose the above records to and may receive the above records from/between:

Person/Facility: _____
Address: _____
City, State Zip: _____ **Phone:** _____
Name: _____

Block 4 – Expirations: This "Authorization" will stay in effect indefinitely. Revocation of authorization must be delivered and signed in writing by specified participant.

Block 5 – Purpose for which you want records disclosed: *Check One* At request of individual To determine my status regarding any illness(es) that has or could affect my practice, to coordinate my care and to monitor my recovery/ rehabilitation.

Block 6 – Authorizing Signature (I authorize the disclosure of all the records/information described and:

- I understand that if the person, agency, or organization that receives the described records/information is not subject to the federal privacy regulations; the records/information may be re-disclosed and no longer protected by those regulations.
- I also understand that certain records may be protected by federal or state law, including alcohol/drug treatment, psychiatric treatment, mental health treatment or communicable disease and unless a restriction is noted in Block 2 above, I am requesting that any and all such protected records be released under this authorization.
- I understand that I may revoke this authorization at any time by delivering a written revocation to **Kansas Nurses Assistance Program, 6405 Metcalf, Suite 502, Overland Park, KS 66202 (913) 236.7575.**
- If I revoke this authorization it will have *no* effect on actions already taken on reliance of this form.
- I understand that I may refuse to sign this form and that my treatment or payment for my treatment will not be affected if I do not sign this form unless my treatment includes research, or the reason for my treatment is to disclose information to another.
- I have read and understood this form. I am the patient/participant listed above in section (1). I also permit disclosure of the records based upon a photocopy of this authorization.

Signature of Patient/Participant

Date of Signature

IMPORTANT NOTE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) or other laws and /or internal policy. 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 information 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.

For referrals not known to the Kansas State Board of Nursing; this release is signed authorizing our office to share information from your file to KBON in the event you become non-compliant with our program.