



Authorization for Release of Protected Health Information
Please fill in ALL blanks

Client's Full Name: _____ DOB: _____

Other Names Used: _____

Telephone Number: _____ SSN: _____

I, _____ authorize:

Adoption Social Work Service
Marcia Kennedy Cordes, Eds, LMSW
PO Box 75523 _____
Wichita, KS 67275 _____
316-371-7226 _____
Email: Marcia@adoptionssocialworkservice.com

To Disclose to OR
 Obtain from

Agency Name: _____

Provider Name (if applicable) _____

Email: _____

Phone: _____

Address (City, State, and Zip) _____

The information to be disclosed is:

- | | |
|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Medical History & Physical | <input type="checkbox"/> Medication Record |
| <input type="checkbox"/> Lab Data/Reports | <input type="checkbox"/> HIV/AIDS Information |
| <input type="checkbox"/> Special Education Records | <input type="checkbox"/> Court Orders/Reports |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Case/Treatment Plan |
| <input type="checkbox"/> Foster Care Licensing/MAPP info | <input type="checkbox"/> Diagnosis/Prognosis |
| <input checked="" type="checkbox"/> Other: adoption home studies, updates and fingerprint results | |

For the treatment dates of _____

I understand that my treatment/health information may contain information relating to: HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law and I authorize disclosure of that information. Any alcohol and/or drug treatment records are protected under federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be redisclosed by the person receiving it. I understand that I may refuse to sign this Authorization 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 person. I understand that I may see and copy the information described on this form as provided by federal regulations, and that I will get a copy of this form after I sign it.

I understand that I can revoke this authorization in writing but that any revocation is not effective for disclosures that have already been made. To revoke authorization, I should contact: Marcia Kennedy Cordes, EdS, LMSW at the above listed contact information.

Signature of Client/Date

Signature of Personal Representative of Client/Date

Signature of Witness/Date

Personal Representative's Relationship to Client

*Kansas SB 119 mandates that all authorizations are no longer valid after one year from the date of signature