



**AREA MENTAL HEALTH CENTER**

“From Head to Heart... You Matter”

**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

Client Last Name	First Name	MI	Date of Birth
Parent/Guardian Name (Last, First)	Address (Street, City, Zip)		Phone #

**I authorize AREA MENTAL HEALTH CENTER to:**

**RELEASE** the following written information:  
(Please check each applicable item)

- Admission Evaluation Report
- Diagnosis
- Treatment Plan(s)
- Psychiatric Consultation Report
- Psychological Evaluation Report
- Discharge Summary
- Progress Review (s)
- Alcohol & Drug Treatment Information
- Hospital Screening
- Progress Notes: FROM \_\_\_\_\_ TO \_\_\_\_\_
- Medical \_\_\_\_\_
- Housing Information \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**OBTAIN** the following written information:  
(Please check each applicable item)

- Admission Evaluation Report
- Diagnosis
- Treatment Plan(s)
- Psychiatric Consultation Report
- Psychological Evaluation Report
- Discharge Summary
- Progress Review (s)
- Alcohol & Drug Treatment Information
- Hospital Screening
- Progress Notes: FROM \_\_\_\_\_ TO \_\_\_\_\_
- Medical \_\_\_\_\_
- Housing Information \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**VERBAL COMMUNICATION** (Please check if applicable)

I authorize verbal communication with the person or agency listed below in order to coordinate treatment, allow discussion of treatment progress, and discuss relevant concerns or issues regarding the above-named client’s treatment.

**TO / FROM – NAME / AGENCY** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE, ZIP:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**RESTRICTIONS** – The information indicated will be disclosed unless there are specific restrictions noted here:

\_\_\_\_\_

\_\_\_\_\_

**THE PURPOSE OR NEED FOR THE DISCLOSURE** (Check all that apply)

- Evaluation / Treatment Planning
- Case Coordination
- Legal Proceedings
- School Placement or Assessment
- Other: \_\_\_\_\_



**AREA MENTAL HEALTH CENTER**

“From Head to Heart... You Matter”

**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION Cont'd**

- 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 also understand that AMHC cannot ensure that the recipient will maintain confidentiality of this information I have authorized to be released.
- I also understand that this authorization will be honored unless revoked verbally or in writing. Revocation may be made at any time except to the extent that action has already been taken. To revoke an authorization, I need to notify AMHC. (KAR 30-60-47 (b)(7), AAPS Standards for Licensure/Certification, Chapter 7,1.a.(7), and CFR-42, part 2)
- I understand that if the person or organization authorized to receive this information is not a health care provider or a health plan, or is not otherwise covered under the federal privacy regulations, the released information may be re-disclosed and will no longer be protected by federal privacy laws. I understand that certain persons or organizations may not re-disclose substance abuse treatment information. (CFR-42, part 2)
- I understand that this authorization is voluntary, and I verify that I have been given the chance to ask and receive answers to questions.
- **I also understand that this authorization will expire (Choose One):** (KAR 30-60-47(b)(6), CFR-42, part 2)
  - One year from this date (i.e., date of signature below)**
  - OR**  **On the following date:** \_\_\_\_\_ (MM/DD/YYYY)
  - OR**  **Upon the following specific event: (Please describe)** \_\_\_\_\_

\*\* Note: If neither a specific date or a specific event is selected this Authorization will automatically expire 90 days after discharge or one year from the date of authorization whichever comes first.

---

Signature of Client (required for minors receiving A/D treatment ages 14 and above) Date

---

Signature of Authorized Representative (if applicable) Date Relationship to client

---

Witness (to signature) Date

EXPIRES: \_\_\_\_\_