Southwest Developmental Services, Inc.

"Helping Kansans with developmental disabilities access quality community services"

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Individual whose information is being disclosed:
Name: _____ Birth Date: _____
Address: _____ Phone: _____
City/State/Zip: _____ SSN: _____

The information may be released to/from:
Name/Agency: _____
Address: _____ Phone: _____
City/State/Zip: _____ Fax: _____

Agency authorized to disclose or receive the information:
Name: Southwest Developmental Services, Inc. (SDSI) _____
Address: 1103 Main Street _____ Phone: (620) 793-7604 _____
City/State/Zip: Great Bend, KS 67530 _____ Fax: (620) 793-7906 _____

The purpose or need of the information is to: (Individual/legal Representative initial appropriate blank)
_____ Eligibility determination for the State of Kansas Intellectual/Developmental Disability Home & Community Based Services
_____ Other: _____

Information authorized to be used and/or disclosed: (Individual/Legal Representative initial all that apply)

_____ Diagnosis Review Summary
_____ Individual Education Plan/504 Plan/Evaluations
_____ Treatment Plan
_____ For Treatment Dates of: _____
_____ Psychological Evaluation/IQ Assessment
_____ Medical Diagnoses
_____ Other: _____

My initials authorize the use or disclosure of records containing the below described information if they are otherwise included within the scope of this authorization. (Individual/Legal Representative initial all that apply)

_____ *I understand that my records are protected under the federal regulations governing Confidently 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 this may include information relating to the diagnosis and treatment of mental, alcohol or other drug dependency, or emotional conditions, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes) ;
_____ * I understand this may include information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations.

VERBAL COMMUNICATION: (Individual/Legal Representative initial)
_____ *I authorize verbal communication with the entity listed above in order to communicate about the information received.

DATE OF EXPIRATION: (Individual/Legal Representative initial)
This authorization will expire on: _____ (One year from date signed if not otherwise specified)
_____ *I understand that I may revoke this authorization at any time by providing a written notice either by mailing or hand-delivering to SDSI, except to the extent that action has been taken in reliance upon it or except as otherwise stated.

_____ _____ _____
Printed Name of Individual **Signature of Individual** **Date**

_____ _____ _____
Printed Name of Representative (*If Applicable)* **Relationship to Individual** **Date**

_____
Representative address and telephone number

_____ _____ _____
Witness Signature **Printed Name** **Date**

Revised 7/9/2018