



PRINT PATIENT NAME:

Last First MI

ID/ #: \_\_\_\_\_

DOB: \_\_\_\_\_ ☐ MALE ☐ FEMALE

## RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize **Vital Core** and **Johnson County Mental Health Center**: ☐ to disclose to \_\_\_\_\_ AND/ OR ☐ to receive from \_\_\_\_\_

\_\_\_\_\_  
(agency, program, or individual, if an individual, identify relationship to client)

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email \_\_\_\_\_

**I hereby give consent to disclose the following information from my medical record to the facility/entity listed above (CHECK ALL THAT APPLY)**

☐ Records related to treatment of \_\_\_\_\_

Dates From \_\_\_\_\_ To \_\_\_\_\_

☐ Physician/Provider's summary of my diagnosis, medication, treatments, prognosis, and recent care.

☐ Admission Reports

☐ Discharge Summary/Reports

☐ X-Ray Reports

☐ Mental Health Records/Reports

☐ Psychiatric Summary Reports

☐ Laboratory Reports

☐ Summary Reports

☐ Special Studies

☐ Immunization History

☐ Other: \_\_\_\_\_

Per the HIPAA Privacy Rule §164.508(c), I understand that once disclosures of the above records have been made, the information may be re-disclosed by the recipient and are no longer protected by federal privacy regulations.

☐ **Substance Abuse Treatment History and Counseling Records – Dates From \_\_\_\_\_ To \_\_\_\_\_**

Per 42CFR Part 2 regulations, I understand that my substance abuse treatment history and counseling records may only be disclosed to the above noted facility and **that any re-disclosure by them is strictly forbidden without my specific consent.**

**Purpose of Disclosure:** ☐ Continuity of care ☐ At my request ☐ Other: \_\_\_\_\_

I understand that I may revoke this authorization in writing at any time except for any previous disclosures made based upon it.

**This authorization expires on this date:** \_\_\_\_\_ OR, upon this event or condition: \_\_\_\_\_

\*If no date or other event is specified, this authorization will expire after one year from today's date.

I sign this willingly, and I release VitalCore Health Strategies, Johnson County Mental Health Center, (provider) \_\_\_\_\_ and the facility from any liability which may result from this disclosure of information.

### SIGNATURES

\_\_\_\_\_  
Individual/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

### SEND RECORDS TO:

☐ Olathe Central Booking Facility

Other: \_\_\_\_\_

101 N. Kansas Ave.

Olathe, KS 66061

Phone: 913-715-5177

Fax: 785-438-4899