JOHNSON COUNTY KANSAS
Mental Health

6000 Lamar, Ste 130, Mission, KS 66202
PH: 913-826-4200 FX: 913-826-1534
Website: jocogov.org/mentalhealth

AUTHORIZATION TO DISCLOSE PROTECTED HEALTHCARE INFORMATION

Office Use ONLY
Immediate Action Needed: ☐ File Only ☐ Request Records ☐ Request Sent Staff Signature

Name of Client	(Maiden Name, if applicable)	Last 4 digits of SSN	DOB	JCMHC ID

I hereby authorize **Johnson County Mental Health Center**: ■ to disclose to AND/ OR ■ to receive from

Johnson County District Attorney's Office; Johnson County District Court-Criminal Court Diversion

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

Address 100 N. Kansas Ave Olathe City/State Olathe, Kansas Zip Code 66061

Phone _____ Fax Number _____ Email _____

Type of records authorized to be disclosed, one or both record types must be marked to be a valid authorization ☐ Mental Health and/or ☐ Substance Abuse

JCMHC to Disclose (mark each that apply)		JCMHC to Receive (mark each that apply)	
■ Acknowledgement of Treatment		■ Acknowledgement of Treatment	
☐ Billing and/or Insurance Info		■ Billing and/or Insurance Info	
■ Diagnosis		☐ Child Welfare Placement	
■ Discharge Summary / Plan		☐ Diagnosis	
■ Intake / Admission Information		☐ Discharge Summary / Plan	
☐ KCPC (Electronic Version ONLY)		☐ Immunization	
☐ Labs		☐ Intake / Admission Information	
☐ Med/Psych Notes (date range)	____/____/____ to ____/____/____	☐ KCPC (Electronic Version ONLY)	
■ Medications Prescribed		☐ Labs	
■ Other:	Monthly Diversion Reports	☐ Med/Psych Notes (date range)	____/____/____ to ____/____/____
☐ Other:		☐ Medical History	
■ Plan of Care / Treatment Plan		☐ Medications Prescribed	
■ Progress Notes (date range)	____/____/____ to ____/____/____	■ Other:	Diversion application/ Affidavit
☐ Progress Summary (letters)		☐ Plan of Care / Treatment Plan	
■ Psychiatric Eval/Reports		☐ Progress Notes (date range)	____/____/____ to ____/____/____
☐ Psychological Eval/Reports		☐ Progress Summary (letters)	
☐ TB Results		☐ Psychiatric Eval/Reports	
☐ UA		☐ Psychological Eval/Reports	
		☐ School Report/IEP/504	
		☐ TB Results	
		■ UA	
		☐ Waiver Documents	

I understand this information will be used for **the following purpose(s)**:

- ■ **Coordinating Client Care/Treatment**
- ☐ **Coordinating Client Care and Billing/Reimbursement**
- ☐ **Court Testimony (Subpoena Required)**
- ☐ **Emergency Contact**
- ☐ **Records are Requested by the Client/Guardian for Personal Use**
- ■ **Other:** court testimony, written or verbal reports with regard to MH Diversion

I understand that the healthcare information may include medical, psychiatric, alcohol and drug abuse, diagnosis or treatment &/or HIV information. Unless otherwise specified, health care records within the last six months of services will be disclosed. I understand that my records are protected by law and cannot be disclosed or re-disclosed without my consent. However, records disclosed from Johnson County Mental Health Center to a non- covered entity may be subject to re-disclosure and no longer protected. I understand that I am not required to authorize the disclosure of my protected healthcare information to receive treatment. I may request a copy of this authorization and the information disclosed. I may revoke this authorization, in writing, at any time with the exception of situations in which Johnson County Mental Health Center has taken action in reliance on the authorization. A photo or electronic copy of this authorization is considered as valid as the original. By signing this authorization I acknowledge I have read and understand the disclosures I have authorized and I have the legal right and authority to sign this document. ***Unless I revoke it earlier, this consent will expire in 365 days, or other length of time indicated.***

☐ **30 Days** ☐ **60 Days** ☐ **90 Days** ☐ **180 Days**

Signature of Client (age 14 or older)	Printed Name of Client	Date Signed

Signature of Parent or Legal Guardian	Printed Name of Parent or Legal Guardian	Date Signed

Client/Guardian may revoke the ROI verbally, by written statement or using the Revocation of Release of Information form. Revocation form and full policy is on our website: jocogov.org/mentalhealth or at any of our locations.

Revocation Disclaimer Substance Abuse Services Only: **If my treatment was ordered by the court, this permission cannot be revoked until I am officially released from confinement, parole, or probation

Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by law. 42 CFR Part 2 and other state and federal laws prohibits unauthorized disclosure of these records.