ELIZABETH LAYTON CENTER
For Hope and Guidance

Revoked: □ Yes Date of Revocation:_____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

Printed Name of Client	Maiden Name (If Applicable)	Last 4 digits of SSN	DOB

I hereby authorize **Elizabeth Layton Center** to: □ **Release to** **and/or** □ **Receive from**

Individual/Agency (if individual is listed, identify relationship to client):_____

Address_____City: _____ State & Zip Code:_____

Telephone:_____ Fax (optional): _____

The following: information from my medical/clinical record may be released and/or obtained as checked (✓):

____Medical/Records; Summary of Assessment & Treatment
____Psychological/Psychiatric Records; Summary of Assessment & Treatment
____ Substance Abuse Attendance, Summary of Assessment & Treatment
____Arresting Officer's Narrative Summary (AOR), BAC and Related Court Documents
____ Appointment Information
____ Income, Payment & Insurance
____HIV Testing or Treatment or Treatment of AIDS & AIDS-related conditions
____Other-Specific Information_____

All records specified above may be requested or disclosed unless restrictions are specified here:_____

I understand that the information shared will be used for the purpose of: □ Treatment □ Evaluation □ Coordination of Care □ Disability Determination □ Fulfill Request From Attorney □ Other – specify reason(s)_____

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above. This authorization to disclose information contained in my medical/clinical records may be revoked by me at any time by providing verbal or written notice, except for any information or record or portion of that record that has already been released. **Unless I revoke this authorization earlier, it will expire in: □ 3 months □ 6 months □ 9 months or it will automatically expire one year after the date it is signed by the client/guardian.**

I understand that I am not required to release confidential information in order to receive treatment. I understand that the information contained in my medical/clinical records contains (or may contain) confidential psychiatric information that may include drug, alcohol and HIV information. This information may be protected by Federal and State Law. I further understand that Elizabeth Layton Center shall only release this information to the agency or person(s) named above. I also understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by Federal or State Privacy regulations, the information described above may be re-disclosed without my permission and no longer protected by those regulations.

X_____ _____
Signature of Client (age 14 or older) Date

_____ _____ _____ _____
Signature of parent, guardian or legal representative Printed Name of Representative Specify Relationship Date

X_____ _____
Signature of Witness Date

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general consent for the release of medical or other information is **NOT** sufficient for this purpose.

❑ **Elizabeth Layton Center - Franklin County**
Attn: Medical Records
PO Box 677
Ottawa, KS 66067
(785) 242-3780 Office
(785) 242-6397 Fax

❑ **Elizabeth Layton Center - Miami County**
Attn: Medical Records
PO Box 463
Paola, KS 66071
(913) 557-9096 Office
(913) 294-9247 Fax