Lawrence Family Therapy, LLC

Release of Information from Lawrence Family Therapy, LLC to Another Agency

Client Name:	Date of Birth:
Guardian (if under 18):	Relationship to client:

By signing this form the above noted client (or guardian) indicates understanding of the following:

- The client (or guardian) is voluntarily waiving a specific right of confidentiality allowing Lawrence Family Therapy to release information to the following agency(s).
- The purpose of this release is to facilitate a comprehensive treatment plan or provided feedback to other parties with a bona fide interest in this case. Lawrence Family Therapy will only release information about a client or former client which is judged by its staff as necessary for evaluation and/or treatment coordination and planning. Specific limitations to this release are noted here:
- Lawrence Family Therapy is not obligated to open its records to another agency, nor to provide any information beyond the scope of this release.
- This release is given voluntarily in accordance with Kansas Statute KSA 59-2931, and KSA 1987 Supp 65-5601 to 65-5605 and all amendments thereto, as well as applicable federal guidelines for the keeping of medical and psychiatric records. Pursuant to those statutes Lawrence Family Therapy may refuse to disclose portions of these records if it is determined in writing that such disclosure will cause harm to or threaten the welfare of the client. Due to Federal law (42 CFR Part 2), no agency or organization may re- release records provided by another, though Lawrence Family Therapy cannot guarantee that the recipient of these records will abide by these regulations.
- This release may be revoked (taken back) at any time, though this will not affect records or information already released. The client (or guardian) must provide a written request to terminate the release. Otherwise, this release will expire 60 days after termination of treatment and must be renewed by the client (or guardian) if records are to be released after that time.

By signing this form the above noted client (or guardian) requests release of information to the following (you must **initial** each agency to which information can be released and provide addresses for those agencies not shown):

☐____ Attorney: Name: ☐______Bert Nash Community Mental Health Center ☐______Community Corrections ☐ DG ☐ FR ☐ JO ☐ JF ☐ JA ☐ WY ☐______Court Appointed Special Advocate (CASA) ☐______District Court (including DA and Judge) County: ☐ DG ☐ FR ☐ JO ☐ JF ☐ JA ☐ WY ☐______DG County Rape Victim/Survivor Services	☐______DCCCA Substance Abuse Services ☐______Juvenile Justice Authority ☐______KVC Behavioral Health ☐______Kansas Children s Service League ☐______Lawrence Memorial Hospital ☐______Lutheran Social Services ☐______Mental Health Center: Name: ☐______Menninger Clinic ☐______ Physician: Name: ☐ ______School Districts, USD:	☐______Soc Security Administration ☐______Services for Alcohol Related Problems (SARP) ☐______The Shelter ☐______Dep Child/Fam Area Office (other): DG ☐ FR ☐ JO ☐ JF ☐ JA ☐ WY ☐ ☐______ Therapist: ☐ Name: ______The Farm ☐______Women's Transitional Care Services ☐______Women's Recovery Center ☐ ______Other Describe:

☐______DCCCA

By signing this form, I indicate that I understand and agree with the terms, nature, extent, and purpose of this release, and acknowledge that all my questions about the release have been asked and answered.

Signature of client or guardian ____________________ Date ____________

Witness ____________________ Date ____________