KU CHILD AND FAMILY SERVICES CLINIC

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Your Name: _____

I hereby authorize KU Child and Family Services Clinic (KU CFSC) to:

[ ] disclose to **[ ] obtain from** **[ ] exchange with**

Name: _____

Address and contact information (for person exchanging information with):

Address: _____
(street) (city) (state) (zip)

Phone: _____ **Fax:** _____

Regarding: _____ **DOB:** _____
(client name)

The information to be disclosed includes (check all that apply):
[ ] Discharge or treatment summary
[ ] Complete medical record (including all treatment records, laboratory test results, psychological records, social/psychological assessments or evaluations, insurance information)
[ ] School reports/educational records
[ ] Other (specify): _____

The purpose of the disclosure(s) is for:
[ ] Further treatment
[ ] Assessment
[ ] Other (specify): _____

I understand that once the uses or disclosures have been made as permitted by this form, the records/information may be subject to redisclosure and no longer protected by federal agency regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time by delivering a written revocation to the KU Child and Family Services Clinic (KU CFSC), but if I do, it will not have any effect on actions the clinic took prior to receiving the written notice. *This consent (unless revoked in writing earlier) expires upon termination of services at the KU Child and Family Services Clinic (KU CFSC)*. I have read and understand this form, and I authorize the use or disclosure of the records/information described above.

Signature of Client or Guardian: _____

(Relationship to Client): _____

Signature of Witness: _____ **Date:** _____

[ ] I consent for this information to be transmitted by facsimile if necessary. I understand that the confidentiality of materials cannot be assured when faxed to another agency.

Signature of Client or Guardian: _____ **Date:** _____

NOTICE TO WHOMEVER DISCLOSURE IS MADE: This information is from records whose confidentiality is protected by federal law. Federal regulations (42 CRF Part 2) prohibit any further disclosure of this information without the specific written consent of the person to whom is pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.