VitalCore Health Strategies
Redefining healthcare

JOHNSON COUNTY KANSAS
Mental Health

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**

SEND RECORDS TO:

☐New Century Adult Detention Center 27745 W. 159th St. New Century, KS 66031 Fax: 913-715-5970

☐Olathe Central Booking Facility
101 N. Kansas Ave.
Olathe, KS 66061
Fax: 913-715-5183