The Caring Center of Wichita, LLC

714 S. Hillside, Wichita KS, 67211 Phone: (316)295-4800 Fax: (316)295-4811

CONSENT FOR RELEASE OF CONFIDENTIAL ALCOHOL AND/OR DRUG TREATMENT INFORMATION

I, _____ , authorize **The Caring Center of Wichita LLC** and:

Person or Agency Name: _____

Address: _____

City, State, Zip: _____

Phone / Fax: _____ / _____

To communicate with and disclose to one another the following information (nature and amount of the information as limited as possible):

Client, type in your initials for information to be released:

_____ Name and presence in treatment
_____ Evaluation and recommendations
_____ Diagnosis
_____ Urinalysis / breath test results
_____ Social security number and date of birth
_____ Medical reports / medications
_____ Services rendered
_____ Entire KCPC history / other bio psychosocial assessment
_____ Progress reports
_____ Discharge date/summary/plan
_____ Treatment plan
_____ Attendance record
_____ Emergency related information
_____ Letter/certificate of completion

The purpose(s) of the disclosure (initial only those that apply):

_____ Assessment/Evaluation
_____ Family Support and engagement
_____ Legal Involvement
_____ Billing & Reimbursement
_____ Emergency situation
_____ Disability Determination
_____ Other (Specify) _____

Coordination of care with:

_____ Treatment/Service provider
_____ Employer/EAP program
_____ School
_____ Child Welfare and/or Custody

I understand that my alcohol and /or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and drug abuse Patient Records, 42 C. F. R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and this consent **expires automatically one year after the date of signature**.

_____ _____
Client or Guardian Signature Date

_____ _____
Witness Signature Date