KPCS
Kansas Professional Counseling Services

316.573.2744 P
316.462.0521 F
info@kpcs.com
www.kpcs.com
PO Box 1104
Manhattan, KS 66505

Authorization for Release of Confidential Information

Kansas Professional Counseling Services

Client Information

Last name: _____ First name: _____ MI: _____

DOB: _____ Last 4 digits of SSN: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Authorization

I, _____, authorize Kansas Professional Counseling Services to:

☐ **Release to** **and/or** ☐ **Receive from**

Name/Agency/Facility: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Fax: _____ Email: _____

KPCS TO RELEASE	KPCS TO RECEIVE	
☐ Attendance Record ☐ Current Diagnosis ☐ Discharge Summary/Plan ☐ Drug and Alcohol Evaluation ☐ Intake Information ☐ Mental Health Evaluation ☐ Mental Health Intake ☐ Treatment Plan ☐ Treatment Progress Report ☐ Verification of Treatment ☐ Other: _____	☐ Attendance Record ☐ Current Diagnosis ☐ Discharge Summary/Plan ☐ Drug/Alcohol Evaluation ☐ Intake/Admission ☐ KCPC ☐ Lab Results ☐ Medical History ☐ Medications Prescribed ☐ Placement History ☐ Other: _____	☐ Psychiatric Evaluation ☐ Psychological Evaluation ☐ RADAC ☐ School Records/Info. ☐ Treatment Plan ☐ Treatment Progress Report ☐ Verification of Treatment ☐ Waiver Documents

It is understood this information will be used for the purpose of: _____.

I authorize KPCS to release/receive this information: ☐ **in writing** ☐ **verbally** ☐ **electronically**

I understand my records are protected by law and cannot be disclosed or re-disclosed without my consent. I understand that I am not required to authorize release of confidential information in order to receive treatment. I have the right to revoke this consent, in writing, at any time except for information that has already been released. Unless I revoke it earlier, this consent will expire in ☐ 30 days, ☐ 60 days, ☐ 90 days, ☐ 180 days, or automatically one year after the date of signature.

_____ _____

Signature of Client (age 14 and older) Date Printed Name of Client

_____ _____

Signature of Parent/Legal Guardian Date Printed Name of Parent/Legal Guardian

Third party disclosure statement: The confidentiality of the information disclosed to you is protected by law. Federal regulations prohibit you from making further disclosure of this information without the written consent of the person to whom it pertains.