AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Regarding:

Last Name First Middle	Date of Birth / /
Maiden name or other names known by	Social Security Number

I _____ authorize the following information to be disclosed:
(**PLACE YOUR INITIALS TO THE LEFT OF EACH ITEM APPROVED**):

Information to be released from:	Information to be released to:
____ The Department for Children and Families (DCF) ____ School District: USD # _____ ____ Medical practitioner, clinic, center or facility _____ ____ Mental health practitioner, clinic, center, or facility _____ ____ Substance Abuse treatment provider _____ ____ Social Service agency or provider _____ ____ Subcontractor agencies providing services to child or family _____ ____ Relatives/kin; prospective adoptive families (as applicable); all participants in the initial 24 hour meeting, family meetings and related case planning conferences and meetings _____ _____ ____ Other: _____	____ The Department for Children and Families (DCF) ____ School District: USD # _____ ____ Medical practitioner, clinic, center or facility _____ ____ Mental health practitioner, clinic, center, or facility _____ ____ Substance Abuse treatment provider _____ ____ Social Service agency or provider _____ ____ Subcontractor agencies providing services to child or family _____ ____ Relatives/kin; prospective adoptive families; (as applicable); all participants in the initial 24 hour meeting, family meetings and related case planning conferences and meetings _____ _____ ____ Other: _____

Information to be released (**PLACE YOUR INITIALS TO THE LEFT OF EACH ITEM APPROVED**):

_____All Information necessary for DCF/CWCMP to provide services requested. _____All academic, achievement or aptitude evaluations and recommendations _____Social, behavioral, psychological, mental or medical histories and evaluations, including psychotherapy notes _____Diagnostic and treatment progress and prognoses _____Results of previous treatment _____Information shared during initial team meeting and initial and all subsequent family meetings or case planning conferences _____Abstract (includes face sheet, history and physical, consults, operative notes, emergency record, lab, radiology, ECG, reports, pathology, physical therapy and rehab) _____Other: _____ _____	Timeframe: (If more than one timeframe is needed for information to be released, complete a separate PPS 0100) _____2 years back with most recent test results _____4 years back with most recent test results _____From birth _____Other

The purpose or reason for the release is: (Optional. If no purpose is stated, all lawful purposes are assumed)

_____
_____

Read before signing:
I understand that the information which I have authorized to be disclosed will be used for the purpose(s) stated. I acknowledge that it is my responsibility to be aware of any rights of confidentiality which I may have regarding the information which I am releasing and that by signing this consent I am waiving my rights, if any, to confidentiality for purposes which I have approved.

If I have authorized the release of information to a person or agency providing services under contract with DCF, I have also authorized release of the information to any person or agency providing that service under sub-contract.

This consent may be revoked in writing at any time prior to any action which has been taken in reliance upon it.

Unless otherwise revoked, this authorization will expire on the following date or event: _____
If I fail to specify an expiration date or event, this authorization will expire 180 days from the date signed.

Signature of person(s) giving consent: _____ Date: _____
Witness: _____ Date: _____

Contact Information for requestee:
Name of Person Requesting Information _____
Relationship to person whose information is being released _____
Email:_____
Phone Number: _____
Mailing Address: _____

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Kansas
Department for Children and Families