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)	____ The Department for Children and Families (DCF)
____ School District: USD # _____	____ School District: USD # _____
____ Medical practitioner, clinic, center or facility _____	____ Medical practitioner, clinic, center or facility _____
____ Mental health practitioner, clinic, center, or facility _____	____ Mental health practitioner, clinic, center, or facility _____
____ Substance Abuse treatment provider _____	____ Substance Abuse treatment provider _____
____ Social Service agency or provider _____	____ Social Service agency or provider _____
____ Subcontractor agencies providing services to child or family _____	____ 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 _____ _____	____ 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: _____	____ 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