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**THE BERT NASH COMMUNITY MENTAL HEALTH CENTER, INC.**  
**Authorization for Release of Protected Health Information (including substance abuse and psychiatric records)**  
**200 Maine, Suite A, Lawrence, KS 66044**

I, \_\_\_\_\_, do hereby consent to and authorize Bert Nash Community Mental Health Center to, as indicated,

obtain from:  release to:  exchange oral information with:  e-mail\*  
\*(e-mail consent form must be signed as well)

\_\_\_\_\_  
Name of Person Facility/Organization  
\_\_\_\_\_  
Address City State Zip  
\_\_\_\_\_  
Telephone Client

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

BNC to Obtain	BNC to Release		BNC to Obtain	BNC to Release	
<input type="checkbox"/>	<input type="checkbox"/>	Presence in treatment. (including dates of service)	<input type="checkbox"/>	<input type="checkbox"/>	Medical history and physical examination.
<input type="checkbox"/>	<input type="checkbox"/>	Intake evaluation, including substance use	<input type="checkbox"/>	<input type="checkbox"/>	Medication Record
<input type="checkbox"/>	<input type="checkbox"/>	Treatment Plan	<input type="checkbox"/>	<input type="checkbox"/>	Physician's orders
<input type="checkbox"/>	<input type="checkbox"/>	Diagnosis, brief description of progress and prognosis	<input type="checkbox"/>	<input type="checkbox"/>	Lab, EKG
<input type="checkbox"/>	<input type="checkbox"/>	Psychological tests or projective assessments	<input type="checkbox"/>	<input type="checkbox"/>	Medical discharge summary
<input type="checkbox"/>	<input type="checkbox"/>	Progress Notes, including therapy notes	<input type="checkbox"/>	<input type="checkbox"/>	Crisis Screening report
<input type="checkbox"/>	<input type="checkbox"/>	Legal Information (including police reports)	<input type="checkbox"/>	<input type="checkbox"/>	Custody Evaluation
<input type="checkbox"/>	<input type="checkbox"/>	Evaluations	<input type="checkbox"/>	<input type="checkbox"/>	Educational records including achievements and assessments. (IEP information, discipline records, school attendance.)
<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse information	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ AIDS status
<input type="checkbox"/>	<input type="checkbox"/>	Scheduling			
<input type="checkbox"/>	<input type="checkbox"/>	Billing/Financial			
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			

**Information is Needed for the Following Purposes:**

- To provide ongoing treatment/continuity of care.
- To provide educational services/ school placement or assessment/ coordination of services with authorized school officials
- Legal Proceedings
- Disability Determination
- To coordinate treatment efforts with my family/concerned person
- To coordinate treatment and continuing care efforts with my employer.
- To enable judges, attorneys, probation/parole officers to support treatment goals or make legal decisions on my behalf (Diversion, Probation, Parole)
- Other: \_\_\_\_\_

**READ CAREFULLY: I understand that my medical/behavioral health records are confidential and that the Bert Nash Center cannot condition treatment based on the willingness or refusal to sign authorizations.**

**I further understand that by signing this authorization, I am allowing:**

- release of information to the agency or person specified above including any drug and/or alcohol information (Drug and/or alcohol abuse information records are specifically protected by federal regulations) (42CFR Part 2)
- Federal Regulations prohibit the recipient of the information from making further disclosure without the specific, written consent of the responsible person, or as otherwise permitted by law or regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. In the event that the person/entity who receives this information is not covered by the federal privacy regulations the information described above may be re-disclosed and no longer protected by the federal regulations.
- This consent may be revoked at any time except to the extent that action has already been taken. This authorization will expire on \_\_\_\_\_. If left blank, this authorization automatically expires 90 days after discharge.
- This authorization to release information is subject to the following restrictions: \_\_\_\_\_

\_\_\_\_\_  
Signature of Client Date

\_\_\_\_\_  
Signature of Parent, Guardian or Legal Representative Relationship to Client Date

\_\_\_\_\_  
Signature of Witness Date

BERT NASH COMMUNITY MENTAL HEALTH CENTER, INC.  
E-Mail Informed Consent Form

Purpose: I agree to allow members of the Bert Nash treatment team correspond via email to myself, other providers, or other contacts as indicated on the release form in regards to my treatment or coordination of services.

Among general e-mail risks are the following:

- E-mail can be immediately broadcast and received by many unintended recipients.
- Recipients can forward e-mail messages to other recipients without the original sender's permission or knowledge.
- Users can easily misaddress an e-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Clients who send or receive e-mail from their place of employment risk having their employer read their e-mail.

BNC Procedures:

- E-mail communication between a client and BNC staff containing information pertaining to the client's diagnosis and/or treatment may be included in the client's medical records.
- Clients should not use e-mail in an emergency because BNC cannot guarantee that any particular e-mail message will be read and responded to within any particular period of time.
- BNC will treat e-mail messages with the same degree of confidentiality as afforded other portions of the medical record.
- BNC will use reasonable means to protect the security and confidentiality of e-mail information. **Because of the risks outlined above, BNC cannot, however, guarantee the security and confidentiality of e-mail communication.**
- BNC may forward e-mail messages within the Center as necessary for diagnosis, treatment, and reimbursement. BNC will not, however, forward the e-mail outside the Center without the consent of the client and following established consent and confidentiality procedures.
- The Center cannot guarantee a response to a client-initiated e-mail.
- Because some medical information is so sensitive that unauthorized disclosure can be very damaging, clients should not use e-mail for communications concerning their diagnosis or treatment of AIDS/HIV infection or other transmittable or communicable diseases.
- If the client consents to the use of e-mail, he/she is responsible for informing the Center of the specific information the client does not want to be sent by e-mail.
- BNC cannot guarantee that electronic communications will be private. BNC will take reasonable steps to protect the confidentiality of client e-mail but is not liable for improper disclosure of confidential information caused by the gross negligence or wanton misconduct of some other person not affiliated with the Center.
- Client is responsible for protecting his/her password or other means of access to e-mail sent or received from BNC to protect confidentiality. BNC is not liable for breaches of confidentiality caused by the client.

You may withdraw consent to the use of e-mail at any time by written communication to BNC by writing to the attention of the Health Information Manager.

I have read the above and agree with the terms of the consent.

Client Name (print)

Client Signature

Date

Guardian/Parent Signature

Date

Relationship to client