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THE BERT NASH COMMUNITY MENTAL HEALTH CENTER, INC.
200 Maine, Suite A, Lawrence, KS 66044
PHYSICIAN NOTIFICATION OF CLINICAL SERVICES
Including that Related to Drug or Alcohol Abuse and Psychiatric Records

- I do not have a primary care physician. (Please sign below)
- I decline to release information or to coordinate treatment with my primary care physician. (Please sign below)
- I wish to coordinate services with my primary care physician. (Please complete form and sign below)

Name of Physician

City

Address
(_____)_____
Phone Number

Dear Doctor,

I am sending this form to advise you that your patient _____ has asked us to advise you that he/she is receiving services at the Bert Nash Community Mental Health Center and would like to enable us to communicate with your regarding his/her care.

Date of Birth: _____ SS#: _____
Intake Clinician: _____ Contact Number: _____

BNC to Obtain	BNC to Release		BNC to Obtain	BNC to Release	
<input type="checkbox"/>	<input type="checkbox"/>	Presence in treatment. (including admission and discharge dates)	<input type="checkbox"/>	<input type="checkbox"/>	Medical history and physical examination.
<input type="checkbox"/>	<input type="checkbox"/>	Intake evaluation	<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, X-ray, 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 (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: _____			

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 drug and/or alcohol information (Drug and/or alcohol 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.
- 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