AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The purpose of this form is to authorize ***Cornerstone Clinic, LLC; 631 E. Crawford Suite 209, Salina, KS 67401*** *to share protected health information with the identified third party for the purposes of treatment, payment, and health care operations. If you refuse to authorize any such disclosure, complete the box labeled "Restriction on Disclosure." Otherwise, please complete the form as indicated.*

MEMBER:

_____

Last Name First Name MI

Date of Birth

THIRD PARTY:

_____

Organization/Individual Name

_____

Address

_____

Telephone/Fax

I authorize *Cornerstone Clinic, LLC* to (check all that apply):

release to
obtain from
discuss with

the third party identified above the specified protected health information listed below for purposes of treatment, payment, and health care operations.

CHECK EACH APPLICABLE ITEM:

_____ Admission Evaluation Report	_____ Hospitalization Screening
_____ Diagnosis Only	_____ Progress Notes from _____ to _____
_____ Treatment Plan(s)	_____ Medical Reports
_____ Psychiatric Consultation Report	_____ Legal Reports
_____ Psychological Evaluation Report	_____ Education Reports
_____ Discharge Summary	_____ HIV/AIDS Information
_____ Progress Review(s)	_____ Other:
_____ Alcohol and Drug Treatment Information	_____

This authorization shall remain in effect until _____ (date) at which time this authorization expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for one year from the date listed below.

I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing verbal or written notice of revocation to ***Cornerstone Clinic, LLC.***

_____

_____

Signature of Member/Member Representative Date

_____

_____

Printed Name of Member Representative

Relationship

_____

Signature of Witness

RESTRICTION ON DISCLOSURE: The sharing of protected health information between any third party who has or is treating the Client and Jenna Krehbiel, LSCSW for the purposes of treatment, payment, or health care operations is not authorized.

_____

_____

Signature of Member/Member Representative Date

_____

_____

Printed Name of Member Representative and Relationship to Member Representative

Address and Phone Number

_____

Signature of Witness

Original to be Filed in Client Record. Copy to Client or Client Representative.