Heartland
Regional Alcohol
& Drug Assessment Center

P.O. Box 1063 • Mission, Kansas • 66222-0063
Phone: 913-789-0951 or 1-800-281-0029 • Fax: 913-789-0954

I, _____ _____
(Name of Customer) (DOB)

authorize and request Heartland Regional Alcohol & Drug Assessment Center to communicate with the following individuals, providers, and/or agencies and exchange (send and receive) through disclosure and/or re-disclosure information needed to coordinate and continue care, treatment and services. By checking yes, I am allowing communication with the listed provider. If I check no, I do not want the information exchanged with that provider.

Yes	No	Individual/Provider/Agency Name
✓	❒	Medicaid and/or Designee; PO Box 3571; Topeka, KS 66601-3571
❒	❒	----------
❒	❒	----------
❒	❒	----------
❒	❒	----------

Yes	No	Types of Information	Yes	No	Types of Information
✓	❒	Assessment Results	❒	❒	Laboratory/X-Ray Reports
✓	❒	Kansas Client Placement Criteria Results	❒	❒	Discharge Information & Summary
❒	❒	Attendance/Non-Attendance in services	❒	❒	Urinalysis Information
❒	❒	Diagnosis	❒	❒	Housing Information
✓	❒	Permission to file Appeal/Grievance if services are denied	❒	❒	Recovery Plan
❒	❒	Other: Please describe:			

The purpose or need for such disclosure is to assist in coordinating my care.

I understand that the information and records disclosed and/or re-disclosed pursuant to this consent are protected under 42 CFR Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 CFR parts 160 and 164, State Confidentiality laws and regulations, and cannot be released without my consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Date, Event or Condition when Consent Expires: _____. In the event no date/event/or condition is specified, this consent expires one year from the date of signing.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Upon request, I will be provided a copy of this form.

_____/_____ _____/_____
Signature of Customer Date Signature of legal guardian, if required** Date

_____
Relationship to Customer

**If signing as legal representative for an adult client a copy of the appropriate legal document(s) granting you the authority to do so must be provided and will be maintained in the customer's chart.