Office of the District Attorney
18th Judicial District

Downtown
525 N. Main, Ste 235
Wichita, KS 67203

Juvenile
1900 E. Morris
Wichita, Kansas 67211

MONTHLY REPORT

AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Information

Name: _____ Social Security #: _____ Date of Birth: _____

Address: _____

I, _____ hereby authorize _____

(Client's name) (Treatment Facility)

to disclose records and information, including Protected Health Information ("PHI"), to the Office of the District Attorney and the 18th Judicial District Court, Wichita, Kansas. I further authorize the facility listed above to discuss matters related to these records and information with representatives of the Office of the District Attorney, for the purpose of assisting me in a legal matter.

The type of information to be disclosed is as follows: case notes, assessments/evaluations, recommendations, admission history, progress in treatment, test results, aftercare plans and discharge summary related to diagnosis and treatment for any medical, psychiatric, emotional or drug/alcohol/substance abuse * corners for examination/treatment date from

_____ to _____

(DATE) (DATE)

This authorization will expire on _____ or upon the termination of the legal matter, but no later than one year from the date listed below.

- I understand I may revoke this authorization at any time by giving notification to the facility listed above. I further understand such revocation will have no effect on actions already taken in reliance on this form.
- I understand that if the person or entity that receives the described records and information is not subject to federal privacy regulations or other privacy laws, the records and information may be re-disclosed and no longer protected.
- I understand that treatment is not conditioned on my giving this authorization.
- I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy or facsimile copy of this form.

Signature of Client: _____ Date:_____

Signature of Representative: _____ Date: _____

Printed Name of Representative: _____

Description of Representative's Authority: _____

Representative's Address: _____ Phone: _____

*** Substance Abuse Treatment Records** are confidential and protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except by the specific written consent of the person to which it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict the use of this information to criminally investigate or prosecute a patient.