



Parsons State Hospital & Training Center
Dual Diagnosis Treatment & Training Services
2601 Gabriel Avenue, PO Box 738
Parsons, KS 67357-0738
Ph: (620) 421-6550 x1695 Fax: (620) 421-3623

I authorize the release of information for:

NAME _____ BIRTH DATE _____

ADDRESS _____ SSN _____

TO FROM Parsons State Hospital & Training Center/Dual Diagnosis Treatment & Training Services

TO FROM The Following Agency/Individual:

Name	Position/Relationship	Phone	
Agency	Street Address		
City	State	Zip	Fax

<p>Information is to include:</p> <p><input type="checkbox"/> All medical, social, psychological, behavioral, educational, psychiatric and other pertinent information</p> <p>OR</p> <p><input type="checkbox"/> Medical <input type="checkbox"/> Social <input type="checkbox"/> School</p> <p><input type="checkbox"/> Special Education <input type="checkbox"/> Behavioral</p> <p><input type="checkbox"/> Psychological <input type="checkbox"/> Psychiatric</p> <p><input type="checkbox"/> Other _____</p>	<p>Information is to be used for:</p> <p><input type="checkbox"/> Placement purposes <input type="checkbox"/> Treatment planning</p> <p><input type="checkbox"/> Consultation and recommendations</p> <p><input type="checkbox"/> To assist with legal proceedings</p> <p><input type="checkbox"/> To assist others in planning/providing services</p> <p><input type="checkbox"/> Educational planning/placement</p> <p><input type="checkbox"/> Other _____</p>
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Signature of Client Date

Signature of Parent/Guardian (relationship) Date

Signature of Witness Date

NOTE: Release will not be considered valid without a witness' signature and the client or parent/guardian signature.

This Authorization expires on _____. If left blank authorization will expire 30 days after the case is closed.

I understand that I am not required to sign this release, and if signed, I may revoke it at any time, except to the extent that is required by law. To revoke this authorization, I may contact PSH&TC in writing. I understand that PSH&TC cannot require a signed release as a condition of services unless permitted by law. I have the right to inspect or copy any consultation recommendations provided by PSH&TC. I understand that records obtained by PSH&TC may include HIV, psychiatric, alcohol, or drug abuse information. Information gathered by PSH&TC may include psychological and behavioral information. This information may be protected by State and Federal laws and regulations. I understand that if the information is collected by someone who is not a health care provider it may be re-disclosed and is no longer protected by privacy regulations. I hereby release and discharge PSH&TC/indicated Agency and the person or entity to or from which the above information is provided/received and their employees from any liability for the release of any information disclosed pursuant to this authorization.