AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Regarding

Last Name:	First:	Middle:	Date of Birth:
Other names known by:		Social Security Number:	

I (We) _____ authorize the following information to be disclosed as indicated below.

PLACE YOUR INITIALS TO THE LEFT OF EACH ITEM APPROVED:

Information to be released from:	Information to be released to:
___ The Kansas Department of Corrections (KDOC): ___ The Department of Children and Families (DCF): ___ School District: USD # _____ ___ Medical practitioner, clinic, center or facility: _____ ___ Mental health practitioner, clinic, center or facility: _____ ___ Social Service agency or provider: _____ ___ Other: _____	___ The Kansas Department of Corrections (KDOC): ___ The Department of Children and Families (DCF): ___ School District: USD # _____ ___ Medical practitioner, clinic, center or facility _____ ___ Mental health practitioner, clinic, center or facility _____ ___ Social Service agency or provider: _____ ___ Other: _____

Information to be released: **(PLACE YOUR INITIALS TO THE LEFT OF EACH ITEM APPROVED)**

___ All information necessary to provide services
___ Academic, achievement or aptitude evaluations and recommendations
___ Social, behavioral, psychological, mental or medical histories and evaluations
___ Diagnostic and treatment progress and prognoses
___ Results of previous treatment
___ Other (specify) _____
_____

The purpose or reason for the release is: (Optional. If no purpose stated, all lawful purposes are assumed)
_____
_____

Read before signing:
I understand that the information which I have authorized to be disclosed will be used for the purpose(s) stated. I acknowledge that it is my responsibility to be aware of any rights of confidentiality which I may have regarding the information which I am releasing and that by signing this consent I am waiving my rights, if any, to confidentiality for purposes which I have approved.

If I have authorized the release of information to a person or agency providing services under contract with DCF, I have also authorized release of the information to any person or agency providing that service under sub-contract.

This consent may be revoked in writing at any time prior to any action which has been taken in reliance upon it. This consent expires upon (date): _____
Signature of person (s) giving consent: _____ Date: _____

_____ Date: _____

Relationship to person whose information is being released_____