

Family Therapy Institute Midwest

Release of Information From FTI to Another Agency

Client Name:	Date of Birth:
Guardian (if under 18):	Relationship to client:

◆ **By signing this form the above noted client (or guardian) indicates understanding of the following:**

- The client (or guardian) is voluntarily waiving a specific right of confidentiality allowing FTI-Midwest to release information to the following agency(s).
- The purpose of this release is to facilitate a comprehensive treatment plan or provided feedback to other parties with a bona fide interest in this case. FTI-MIDWEST will only release information about a client or former client which is judged by its staff as necessary for evaluation and/or treatment coordination and planning. Specific limitations to this release are noted here:
- FTI-MIDWEST is not obligated to open its records to another agency, nor to provide any information beyond the scope of this release.
- This release is given voluntarily in accordance with Kansas Statute KSA 59-2931, and KSA 1987 Supp 65-5601 to 65-5605 and all amendments thereto, as well as applicable federal guidelines for the keeping of medical and psychiatric records. Pursuant to those statutes FTI-Midwest may refuse to disclose portions of these records if it is determined in writing that such disclosure will cause harm to or threaten the welfare of the client. Due to Federal law (42 CFR Part 2), *no agency or organization may re-release records provided by another*, though FTI-Midwest cannot guarantee that the recipient of these records will abide by these regulations.
- This release may be revoked (taken back) at any time, though this will not affect records or information already released. The client (or guardian) must provide a written request to terminate the release. Otherwise, this release will expire 60 days after termination of treatment and must be renewed by the client (or guardian) if records are to be released after that time.

◆ **By signing this form the above noted client (or guardian) requests release of information to the following** (you must *initial* each agency to which information can be released and provide addresses for those agencies not shown):

<input type="checkbox"/> _____ Attorney: Name: <input type="checkbox"/> _____ Bert Nash Community Mental Health Center <input type="checkbox"/> _____ Community Corrections <input type="checkbox"/> DG <input type="checkbox"/> FR <input type="checkbox"/> JO <input type="checkbox"/> JF <input type="checkbox"/> JA <input type="checkbox"/> WY <input type="checkbox"/> _____ Court Appointed Special Advocate (CASA) <input type="checkbox"/> _____ District Court (including DA and Judge) County: <input type="checkbox"/> DG <input type="checkbox"/> FR <input type="checkbox"/> JO <input type="checkbox"/> JF <input type="checkbox"/> JA <input type="checkbox"/> WY <input type="checkbox"/> _____ DG County Rape Victim/Survivor Services <input type="checkbox"/> _____ DCCCA Family Preservation Services	<input type="checkbox"/> _____ DCCCA Substance Abuse Services <input type="checkbox"/> _____ Juvenile Justice Authority <input type="checkbox"/> _____ Kaw Valley Center <input type="checkbox"/> _____ Kansas Children's Service League <input type="checkbox"/> _____ Lawrence Memorial Hospital <input type="checkbox"/> _____ Lutheran Social Services <input type="checkbox"/> _____ Mental Health Center: Name: <input type="checkbox"/> _____ Menninger Clinic <input type="checkbox"/> _____ Physician: Name: <input type="checkbox"/> _____ School Districts, USD:	<input type="checkbox"/> _____ Soc Security Administration <input type="checkbox"/> _____ Services for Alcohol Related Problems (SARP) <input type="checkbox"/> _____ The Shelter <input type="checkbox"/> _____ SRS Area Office (other): <input type="checkbox"/> DG <input type="checkbox"/> FR <input type="checkbox"/> JO <input type="checkbox"/> JF <input type="checkbox"/> JA <input type="checkbox"/> WY <input type="checkbox"/> _____ Therapist: Name: <input type="checkbox"/> _____ The Farm <input type="checkbox"/> _____ Women's Transitional Care Services <input type="checkbox"/> _____ Women's Recovery Center <input type="checkbox"/> _____ Other Describe:
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◆ **By signing this form, I indicate that I understand and agree with the terms, nature, extent, and purpose of this release, and acknowledge that all my questions about the release have been asked and answered.**

Signature of client or guardian

Date

Witness

Date