A-I-D Multi-Service Team
Multi-Agency Consent for the Release of Confidential Information

_____ _____ _____-_____-_____
(Name of Client) (DOB) (SSN)

The purpose of this form is to allow me to choose how my services are coordinated. I understand that this is my decision to make and that I can change my mind. If I change my mind, I need to make a written request to any of the listed agencies to cancel this consent. I also understand that I can ask a staff member to assist me with this process. If I have a legal guardian, my guardian shall sign or cancel this consent on my behalf.

By checking yes, I am allowing these providers to communicate and exchange information needed to coordinate and continue care, treatment and services. If I check no, I do not want the information exchanged with that provider.

Yes	No	**Provider/Agency Name**
❒	❒	City of Lawrence Municipal Court staff
❒	❒	Seventh Judicial District Court staff
❒	❒	Defense Attorney:
❒	❒	District Attorney's Office
❒	❒	City of Lawrence Prosecutors' Office
❒	❒	DCCCA, Inc.
❒	❒	Douglas County Sheriff's Office/Reentry
❒	❒	Assessments, LLC
❒	❒	Heartland Regional Alcohol and Drug Assessment Center
❒	❒	Lawrence Community Shelter
❒	❒	Lawrence-Douglas County Housing Authority
❒	❒	Kansas Department for Children and Family Services
❒	❒	Other:

Yes	No	Types of Information	Yes	No	Types of Information
❒	❒	Admit/Discharge Dates	❒	❒	Criminal History
❒	❒	Assessments	❒	❒	Release/Discharge Information
❒	❒	Medications	❒	❒	Verbal Contact
❒	❒	Housing Information	❒	❒	Employment Information
❒	❒	Substance Abuse Client Status, Assessment Results & Treatment Plan	❒	❒	General Case Management information

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 treatment services are NOT contingent upon or influenced by my decision to permit the information release.
- I understand that the information and records disclosed pursuant to this consent may be 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. State and Federal regulations prohibit any further disclosure of such information and records without my specific written consent unless otherwise permitted by such regulation.
- I understand this includes all health information pertaining to any medical history, mental or physical condition, and treatment received (including services provided at a Community Mental Health Center and/or information related to HIV/AIDS status) in the possession, custody or control of the parties identified in this document, regardless of when such information was generated.

_____/_____ _____/_____
Signature of Client Date Witness Date

_____/_____ _____
Signature of legal guardian, if required Date Relationship to consumer