Heartland
Regional Alcohol
& Drug Assessment Center

P.O. Box 1063 • Mission, Kansas • 66222-0063
Phone: 913-789-0951 or 1-800-281-0029 • Fax: 913-789-0954

_____ _____
Name of Client – Please Print Date of Birth

I authorize and request Heartland Regional Alcohol & Drug Assessment Center to communicate with the following individuals, providers, and/or agencies to exchange (send and receive) through disclosure and/or re-disclosure, information needed to coordinate and assist in coordinating my care, treatment and services.

Individual / Provider / Agency Name
Designee of Substance Abuse Center of Kansas (SACK); Wichita, KS; Phone 1-316-267-3825
Designee of Beacon Health Options/Value Options of Kansas; 100 SE 9th Street, Suite 501,Topeka, KS 66612; Phone: 1-866-645-8216
Designee of Kansas Department for Aging & Disability Services (KDADS) Behavioral Health Services – AAPS; 503 S. Kansas; Topeka, KS 66603
Cenpatico/Sunflower Health Plan 8325 Lenexa Drive, Overland Park, KS 66214
Cenpatico/Sunflower State Health Plan, Attn: Referral Department, 504 Lavaca, Suite 850, Austin, TX Phone: 1-512-406-7200; Fax: 1-866-694-3649
United Healthcare/Optum, 10895 Grandview Dr. Bldg 24, Suite #200, Overland Park, KS 66211; Phone: 1-855-802-7095 Fax: 1-855-657-3526
Amerigroup Kansas, Inc. Attn: BH Department, Bldg #32, 9225 Indian Creek Parkway, Overland Park, KS 66210; Phone: 1-800-454-3730; Fax: 1-800-505-1193

By initialing, I am allowing communication with the entities noted above.

_____ Alcohol or Substance Use Information and/or Records **(CLIENT INITIALS ARE REQUIRED)**

To Include: • Clinical Treatment Plans / Notes • Authorizations • Denials / Grievances / Appeals • Claims Info / EOB's

I understand that the information and records disclosed and/or re-disclosed pursuant to this consent are protected under 42 CFR Part 2 - Confidentiality of Substance Use Disorder Patient Records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Health Information Technology for Economic & Clinical Health (HITECH) and 45 CFR parts 160 and 164, and State Confidentiality laws & regulations. This information cannot be released without my consent unless otherwise provided for by the regulations.

This authorization shall be in force and effect for one year or until I revoke it, in the manner described below or until (**insert expiration date or event**) _____ (whichever is shorter).

- I may revoke this consent at any time. But if revoked, the revocation will not affect the disclosure of any information that has already been disclosed / re-disclosed.
- As I authorize the release of alcohol or substance use information to a healthcare organization that is not my treating provider, I have the right, for the next two years, to request a list of entities to which my information has been disclosed, by contacting the organization directly and requesting that information in writing.
- I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or healthcare operations, as permitted by law. I will not be denied services if I refuse to consent to a disclosure for other purposes.
- Upon request, I will be provided a copy of this authorization.

_____ / _____
Signature of Client Date

_____ / _____ _____
Signature of Legally Authorized Representative * Date Relationship to Client

**** If signing as the individual's Legally Authorized Representative, attach a copy of the appropriate legal document(s) granting you authority. Examples would be a health care power of attorney, a court order, guardianship papers, etc. A financial or business power of attorney is NOT sufficient.***