CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

CDDO of Southeast Kansas
P O Box 187
Columbus KS 66725

Phone: (620) 429-8985
FAX: (620) 429-8723

Client Name:_____ Address: _____

Date of Birth: _____ Social Security Number: _____

I HEREBY AUTHORIZE CDDO OF SEK TO OBTAIN FROM

Name of Individual or Agency: _____

Address, City, State, Zip: _____

Telephone Number: _____ Fax Number: _____

THE FOLLOWING INFORMATION: (**Client/legal representative initial appropriate blank**)

☐ Medical Records to include diagnosis of developmental delay
☐ Psychological Evaluation to include full scale IQ with DSM codes
☐ Other as requested _____

THE PURPOSE OR NEED IS TO:

Obtain information for eligibility for the Intellectual /Developmental Disabled waiver.

THIS CONSENT TO DISCLOSE MAY BE REVOKED BY ME AT ANY TIME UPON MY **WRITTEN REQUEST** EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THIS CONSENT (UNLESS EXPRESSLY REVOKED EARLIER) EXPIRES **ONE YEAR FROM THE DATE SIGNED.**

Client Signature: _____ Date: _____

Printed Name of Client: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name of Parent/Guardian: _____ Relationship: _____

Witness Signature: _____ Printed Name: _____

Title: _____ Agency: _____

The above signed acknowledges that he/she is aware that certain information that he/she is consenting to release is confidential and protected by Federal and State Law. The undersigned acknowledges upon signing this consent that they are waiving their rights under these laws and that they are aware of the specific protections they are afforded or they are waiving their right to being informed of the specific provisions of these laws, Statute 42 CFR – Part 2.