CONSENT FOR RELEASE OF INFORMATION

CDDO of Southeast Kansas
PO 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 INFORMATION 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 code
- ◯ 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 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 PFR – Part 2.