Case Management Services, Inc.

CMS, Inc.

7600 W. 75th Street
Overland Park, KS 66204

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Name: _____ SS#: _____

Date of Birth: _____ Home#: _____ Work#: _____

Address: City: State: KS Zip:

I hereby authorize the agencies listed below and/or person listed below to exchange information regarding my case. This information shall be used for the benefit of mutual planning of my services.

Agency/Person	Address	Phone Number

And

Agency/Person

Case Management Services, Inc 7600 W. 75th St. Overland Park, Ks. 66204

The type and amount of information to be used or released is checked below:

_____ All Records/Information
_____ Dental
_____ Medical Records, including Diagnosis
_____ Program Plans, Evaluations & Assessments
_____ Psychological Evaluation(s), IQ Scores & Tests
_____ School Records
_____ Social History
_____ Other:

This information may be released in the following format(s):

_____ Audio/Visual
_____ Electronic
_____ Verbal
_____ Written
_____ Other _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that this authorization may be revoked by the person served and/or their guardian at any time except to the extent the action has already taken place. I understand that if I revoke this authorization, it must be in writing and presented to Case Management Services, Inc. This authorization is valid until revoked.

I have read the above Authorization for Release of Information/Permission to Obtain and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this release.

Date: ____ / ____ / _____ Signature of Person Served: _____

Date: ____ / ____ / _____ Signature of Authorized Representative: _____

Please complete the following section if signed by Parent/Guardian or Authorized Representative

Printed Name of Parent/Guardian or Authorized Representative: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Relation to Person Served: _____