TRI-KO INC. COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION CDDO
Miami, Linn, & Anderson Counties

THIS FORM MUST BE COMPLETED AND RETURNED TO CDDO

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

TO: NAME/COMPANY	RE:
ADDRESS	
CITY, STATE, ZIP CODE	DATE OF BIRTH

☒ **You are hereby authorized to furnish Tri-KO, Inc., or its representative, any Protected Health Information (PHI) identified below which you may possess concerning the above named individual in written, electronic, or verbal form.**

TRI-KO, INC. CDDO
301 FIRST STREET, BOX 2
OSAWATOMIE, KS 66064

☒ Psychological Evaluation	☒ Physical Examination
☒ School Testing & Evaluation, IEP	☒ Psychiatric Evaluation
☒ Vocational Evaluation	☒ Speech Evaluation
☒ Individual Counseling Notes	☒ Medical Records as permitted by law
☒ Vision Examination	☒ Other (specify) School Records _____
☒ Hearing Examination	☐ Other (specify)_____

☒ **Tri-Ko, Inc. CDDO is hereby authorized to provide the following Protected Health Information (PHI) concerning the above named person to the person/ company indicated in written, electronic, or verbal form:**

☒ Person Centered Plan	☒ BASIS Assessment
☒ Plan of Care and Service Information	☒ Behavior Support Plan
☒ Records used to determine ID/DD eligibility	☐ Other (specify) _____
☒ Medical Records as permitted by law	☐ Other (specify) _____

I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. I understand that I may revoke this authorization by notifying TRI-KO, CDDO in writing of my desire to revoke it. I understand revoking this authorization will not have any effect on actions taken by TRI-KO, CDDO in reliance on this authorization. I understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

_____
Printed Name of Applicant or Legal Representative

_____ _____
Signature of Applicant or Legal Representative Date

_____
Expiration Date (not to exceed 12 months from date signed)

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