



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

<input checked="" type="checkbox"/> Psychological Evaluation	<input checked="" type="checkbox"/> Physical Examination
<input checked="" type="checkbox"/> School Testing & Evaluation, IEP	<input checked="" type="checkbox"/> Psychiatric Evaluation
<input checked="" type="checkbox"/> Vocational Evaluation	<input checked="" type="checkbox"/> Speech Evaluation
<input checked="" type="checkbox"/> Individual Counseling Notes	<input checked="" type="checkbox"/> Medical Records as permitted by law
<input checked="" type="checkbox"/> Vision Examination	<input checked="" type="checkbox"/> Other (specify) <u>School Records</u> _____
<input checked="" type="checkbox"/> Hearing Examination	<input type="checkbox"/> 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:

<input checked="" type="checkbox"/> Person Centered Plan	<input checked="" type="checkbox"/> BASIS Assessment
<input checked="" type="checkbox"/> Plan of Care and Service Information	<input checked="" type="checkbox"/> Behavior Support Plan
<input checked="" type="checkbox"/> Records used to determine ID/DD eligibility	<input type="checkbox"/> Other (specify) _____
<input checked="" type="checkbox"/> Medical Records as permitted by law	<input type="checkbox"/> Other (specify) _____

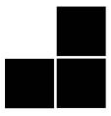
I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. I understand that I may revoke this authorization by notifying TRI-KO, CDDO in writing of my desire to revoke 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)



**TRI-KO
INC.**

COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION
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

<input checked="" type="checkbox"/> Psychological Evaluation	<input checked="" type="checkbox"/> Physical Examination
<input checked="" type="checkbox"/> School Testing & Evaluation, IEP	<input checked="" type="checkbox"/> Psychiatric Evaluation
<input checked="" type="checkbox"/> Vocational Evaluation	<input checked="" type="checkbox"/> Speech Evaluation
<input checked="" type="checkbox"/> Individual Counseling Notes	<input checked="" type="checkbox"/> Medical Records as permitted by law
<input checked="" type="checkbox"/> Vision Examination	<input checked="" type="checkbox"/> Other (specify) <u>School Records</u>
<input checked="" type="checkbox"/> Hearing Examination	<input type="checkbox"/> 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:

<input checked="" type="checkbox"/> Person Centered Plan	<input checked="" type="checkbox"/> BASIS Assessment
<input checked="" type="checkbox"/> Plan of Care and Service Information	<input checked="" type="checkbox"/> Behavior Support Plan
<input checked="" type="checkbox"/> Records used to determine ID/DD eligibility	<input type="checkbox"/> Other (specify) _____
<input checked="" type="checkbox"/> Medical Records as permitted by law	<input type="checkbox"/> 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)