





**Behavioral Sciences Regulatory Board**  
**712 South Kansas Avenue**  
**Topeka, Kansas 66603-3817**  
**(785) 296-3240**  
**(785) 296-3112 (FAX)**

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**GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_, hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization authorized to provide the information:

\_\_\_\_\_.

2. The Kansas Behavioral Sciences Regulatory Board (Board), its representatives, agents or employees are specifically authorized to receive and use my health information. Please send information to:

Kansas Behavioral Sciences Regulatory Board  
ATTENTION: \_\_\_\_\_  
712 S. Kansas Avenue  
Topeka, Kansas 66603-3817

3. I hereby waive my privilege of confidentiality concerning my care and treatment, or the care and treatment of my minor child or ward, and authorize any person, including, but not limited to, mental health care agencies, mental health providers, health care providers, clinics, employers (past and present), attorneys, insurance companies, government agencies, or other public or private agencies to release to the Kansas Behavioral Sciences Regulatory Board, its representatives, agents or employees, any and all information about me or my minor child, including documents, reports, records, files, testimony, police reports or any other document regardless of form or content.

4. The purpose of this request is to provide the Board access to information necessary in furtherance of health oversight activities.

5. I understand I have the right to revoke this authorization at any time by notifying the Board in writing at 712 S. Kansas Avenue, Topeka, Kansas 66603-3817. I understand that the revocation is effective only after it is received by the Board. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it to other health oversight agencies and law enforcement entities as permitted by state law.

7. I understand that if I do not sign this authorization, the Board may not be able to investigate my complaint fully. I also understand that in furtherance of health oversight activities, the Board possesses subpoena power that permits it to command the disclosure of my health information from certain individuals and entities without my permission. This authorization is intended to permit individuals and entities not subject to the Board's subpoena power to provide copies of my health information to the Board.

8. I understand that this authorization will expire upon completion of the Board's investigation into the matter(s) about which I am complaining, or upon the completion of any legal proceedings that might arise out of my complaint, whichever event is later.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

If parent or guardian, name of the minor child: \_\_\_\_\_

\_\_\_\_\_  
Patient's Date of Birth



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**NARRATIVE:**

Please describe in detail all allegations against the person whom you are filing the report. Describe each incident with specific dates and include names of witnesses. Include your relationship to the Licensee/Professional, and if you were a client, the reason you saw the professional (i.e. was it court ordered, was the therapist court appointed, or was the therapist a mediator). Attach copies of any documents you have concerning the allegations. Use additional sheets if necessary.  
(Reminder: Who, What, When, Where, Why and How.)

DATE: \_\_\_\_\_ PERSON WRITING NARRATIVE: \_\_\_\_\_

The statements I have made are true and correct to the best of my knowledge and belief. I acknowledge that the Behavioral Sciences Regulatory Board may provide a copy of this form to the person against whom the allegations are made. I also agree to testify in any hearings that may arise as a result of these allegations.

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_