The Kearney Center

A Facility for Comprehensive Emergency Services

Discharge Agreement

Before discharging patients to The Kearney Center, the hospital discharge personnel needs to speak directly to a Kearney Center representative concerning that patient's plan of care. Kearney Center representatives that could approve this are Jacob Reiter and Bret Oglesby.

The Kearney Center is emergency housing for individuals, who for one reason or another, have no place to stay. Staff at The Kearney Center are not equipped to serve patients that need assisted living. The Kearney Center is not appropriate for everybody; patients have to be able to care for themselves. We need to be made aware of any emergency medical concerns and mental health issues so that we can notify staff to ensure the safety of the patient as well as others.

We consider every reasonable attempt to coordinate discharge of a patient or client from your facility to the Kearney Center. To facilitate this we require that discharge planning and coordination begin by contacting the Center during normal business hours (8:00am- 4:30pm), Monday-Friday at 850-792-9000 x 125 and ask to speak with the Clinical Director or Director of Operations. **Failure to properly coordinate with Center staff may result in the patient or client being denied access to our facility**.

Patient Release of Information

This Release of Information authorizes The Kearney Center access to your discharge instructions/ summaries and medications list. The information collected is used for the purpose of Coordination of Treatment/ Continuity of Care. By signing below, you are agreeing to allow the Kearney Center access to the information collected on you by _____.

(Name of Referring Medical/Mental Health Facility)

PERSON TO USE (RECEIVE) INFORMATION:

Name (Releasee): _Bret Oglesby or Jacob Reiter_____

Address _2650 Municipal Way, Tallahassee FL 32304_____

Phone: 850-792-0000 x 125

Fax: 850-536-6053

AUTHORIZATION FOR RELEASE OF INFORMATION:

Printed Name: _____

Signature of Patient: _____

SSN _____

DOB ____/____/____

Date _____

This authorization will expire on _____ If no date is specified, it will expire ninety (90) days after the date is signed.