The Kearney Center

A Facility for Comprehensive Emergency Services

Discharge Agreement

Before discharging patients to the Kearney Center, hospital discharge personnel need to speak directly to a Kearney Center representative concerning that patient's plan of care. Hospital discharge personnel must also submit a completed discharge agreement to the Kearney Center. **Along with this document, please attach the patient's current plan of care, current list of medications, and any other supporting medical documents**.

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 or medical respite care. The Kearney Center is not appropriate for everyone; patients must 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 103. Please note that The Kearney Center may not be able to respond until the following business day. **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:

REFERING AGENCY:

Name of Referring Medical/Mental Health Facility: _____

Name of Referring Staff Member: _____

Contact Information for Referring Staff Member: _____

AUTHORIZATION FOR RELEASE OF INFORMATION:

Printed Name: _____

Signature of Patient: _____

DOB: _____

SSN: XXX-XX- _____

Date: _____

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

PERSON TO USE (RECEIVE) INFORMATION:

Name (Release): CESC

Address: 2650 Municipal Way, Tallahassee FL 32304

Phone: (850)-792-9000 x 103

Fax: (850)-536-6053