Kansas City Psychiatric Group, P.A.
4500 College Blvd., Suite 304
Overland Park, KS 66211-1760
913-338-0400
913-338-0428 Fax

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: _____ DOB:	Person making request: _____ Relationship:
Agency/Person to Release Information:	**Agency/Person to Receive Information:**
_____ (Name) _____ (Address-street) _____ (city, state, zip) Phone#_____ Fax#_____ Fax transmission authorized, if needed? Yes _____ No _____	_____ (Name) _____ (Address-street) _____ (city, state, zip) Phone#_____ Fax#_____ Fax transmission authorized, if needed? Yes _____ No ____
This information is requested for the following purpose: ☐ Continuity of care ☐ Application/reapplication for benefits ☐ Disability determination ☐ Legal proceedings ☐ Other(specify):_____ _____	The minimum necessary information to accomplish the purpose is: ☐ Medications ☐ Assessments ☐ Treatment Plan ☐ Lab ☐ Progress Notes ☐ Referrals ☐ Discharge Summary ☐ Provider Discharge ☐ Form completion ☐ Letter regarding: _____

☐ WRITTEN INFORMATION ONLY
☐ VERBAL INFORMATION ONLY
☐ WRITTEN AND VERBAL INFORMATION

READ CAREFULLY

My signature below acknowledges my understanding of the following:

1. I understand that medical/behavioral health records are confidential. By signing this authorization I am allowing the release of information, including any substance abuse information, to the agency or person specified above. Transfer of the information released above to persons or agencies not specified is prohibited by law.
2. I understand that signing this authorization is not a condition of receiving treatment here.
3. This authorization includes both information presently compiled and information to be compiled during the course of the client's treatment at this agency.
4. I understand that there is a potential for the information disclosed to be subject to re-disclosure by the recipient and no longer protected by this law.
5. This consent is subject to revocation by the undersigned at any time by completing the notice of revocation at the bottom of the page.
6. This consent to release information (unless revoked earlier) will automatically terminate one year from the date of signing, or six months from the date of signing if the purpose is for other than treatment.
7. .Specify any special conditions, date, events that would result in revocation: _____
8. I understand that I have the right to receive a copy of this authorization and to request to see or copy the information disclosed.
9. This authorization to release information is subject to the following restrictions: _____

Patient Signature: _____ Parent or Legal Guardian/Custodian: _____	Date: _____

Notice of Revocation- This revocation cancels my authorization given above

Patient Signature: _____ Parent or Legal Guardian/Custodian: _____	Date: _____

Note: A copy of this authorization is as valid as the original.

Client Name: ID #: