Mileham
PSYCHIATRIC SERVICES

# Medical Information Release Form
# (HIPAA Release Form)

Patient Name: _____ Date of Birth: _____/_____/_____

## Consent for Release of Confidential Information

[ ] I authorize the exchange of information between Mileham Psychiatric Services and:

Name:_____
Address:_____
City/St/Zip:_____
Phone: _____ Fax: _____

This release of Information will remain in effect until terminated by me in writing or 1 year from today's date.

I acknowledge that I am aware that certain information I am consenting to release is confidential and protected by Federal and State Law. I acknowledge upon signing this consent that I am waiving my rights under these laws and that I am aware of the specific protections I am afforded or I am waiving my right to being informed of the specific provision of these laws. Statute – 42CFR-Part 2. K.S.A. 65-5601 to 65-5601 to 65-5605, inclusive.

It is expressively understood that photocopies/fax of this authorization shall be as valid as the original.

Patient Signature: _____ Date: ____/____/____

Parent/Legal Representative Signature: _____ Date: ____/____/____