Authorization to Disclose/Release Information

I, _____, hereby authorize Kansas City Psychology Center, LLC and its clinicians to disclose, to the point necessary, the specific information described below, only for the purposes and parties described below.

I authorize the discussion and/or distribution of records related to appointments and findings related to **(circle option 1 or 2)**

1: All psychological evaluation, therapy records, or contact records or **2**: (indicate specific information and/or date range)_____.

This may include physical health information, including any HIV information; mental health information, including any history of drug and alcohol use; medications; and any other pertinent information, such as employment or school information, pertaining to the evaluation and/or treatment unless otherwise specified, which could limit the records disclosed.

Examinee/Patient Name:_____.

Information to Be Disclosed/Released to:_____.

Address:_____.

_____.

Phone: _____

Fax:_____

Records method: ____ Verbal only ____ Fax ____Email ____Digital media device ____Paper

*I acknowledge that unsecured email cannot be guaranteed to remain private and accept all risks if I choose that method.

This authorization shall remain in effect from the date signed below until 1 year unless otherwise specified or revoked in writing.

_____(period if less than 1 year)

I understand that:

- I may inspect or obtain a copy of the information disclosed.
- I may revoke this authorization in writing by contacting Kansas City Psychology Center, LLC at the fax number listed below.
- This authorization is giving Kansas City Psychology Center, LLC and its clinicians the right to discuss the information listed above with the person or entity identified above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer under the control of Kansas City Psychology Center, LLC or HIPPA protections depending upon its use.
- I may refuse to sign this authorization, and it will not be a condition of treatment, evaluation, or payment.
- I understand that there are certain legal exceptions that might apply in which my request can be denied or limited of which I will be notified if applicable.

Signature of examinee/patient or authorize representative:_____

Date:_____ Please fax completed form to : (816) 447-3944