KANSAS CITY PSYCHIATRIC & PSYCHOLOGICAL SERVICES, LLC

AUTHORIZATION FOR THE RELEASE/EXCHANGE OF INFORMATION

*I understand that my records may be protected under the Federal Confidentiality Regulations (42 CFR Part 2) and, if so, cannot be disclosed without my written consent otherwise provided the regulations and/.or under state specific provisions.

*I understand that my records may contain information regarding my mental health, substance use or dependency, sexuality, suicidallty, and may contain confidential HIV (AIDS) related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

Patient Name ________________________________
Date of Birth ____________________________ Social Security # _________________________
Street Address ____
City_____________________________ State _____________ Zip Code _______________________
I Authorize ___________________ to: ☐ Exchange with ☐ Release to ☐ Obtain from the party I have indicated below

Name
Relationship
Address
City/State/Zip
Phone Number
Fax Number

I authorize the release/exchange of the following medical records/information (check all applicable):

☐ All materials in records
☐ Medical History
☐ Psychosocial History
☐ Assessment & Diagnosis
☐ Progress Notes
☐ Treatment Plans
☐ Substance Abuse
☐ Medication/ Treatment
☐ Psychological Testing
☐ Discharge Summary
☐ Attendance Summary
☐ Only in an Emergency
☐ Other _____________

This Information is required for (check all applicable):

☐ Continuity of Care
☐ Insurance/Managed care review
☐ Keep Patient's parents aware of treatment
☐ Summary of previous treatment
☐ Other _____________

I understand that the information or records listed above will not be used for any purpose other than the intended use. The release of this information to parties other than those named above is prohibited. Furthermore, the records requested and all copies of the information will be destroyed or returned before or immediately after the date listed below.

I understand that I may revoke this authorization at any time, unless action has already been taken on it, by giving written notice to the parties below.

This authorization automatically expires in one year unless otherwise specified on _______________ (specific date)

My authorization is withdrawn if any of the following occur:

Event: ____

Condition: ____

________________________________ ___________________ ___________
Signature of Patient/Legal Guardian Relationship to Patient Date

Signature of Witness: ____ Date: _____________