PSYCHIATRIC ASSOCIATES

Foxhill Medical Building
4601 W. 109th Street, Suite 208
Overland Park, KS 66211
P (913) 438-8221 / F (913) 438-7709

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____ _____ _____
(Patient Maiden name, if applicable) (Social Security Number) (Date of Birth)

Request and authorize Psychiatric Associates

___To release to ___To obtain from ___ To exchange verbal information with

Name _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Psychiatric Associates To Release:		Psychiatric Associates To Receive:	
☐All		☐All	
☐Intake Report	☐Medical history & Physical	☐Intake Report	☐Medical History & Physical
☐Diagnosis	☐Lab Results	☐Diagnosis	☐Lab Results
☐Treatment Plan	☐Medications Prescribed	☐Treatment Plan	☐Medications Prescribed
☐Psychotherapy notes	☐School Records/Reports	☐Psychotherapy Notes	☐School Records/Reports
☐Psychiatric Evaluation	☐Immunization Records	☐Psychiatric Evaluation	☐Immunization Records
☐Progress Reports	☐Alcohol & Drug Treatment Records	☐Progress Reports	☐Alcohol & Drug Treatment Records
☐Summary of Treatment	☐Other (specify)_____	☐Summary of Treatment	☐Other (specify)_____

It is understood this information will be used for the purpose of _____

_____

I understand that my treatment records may include medical, psychiatric, alcohol or drug abuse information. I understand that my records are protected by law and cannot be disclosed without consent. I understand that I may revoke this consent at any time except for information that has already been sent. Unless I revoke it earlier this consent will expire in

☐ **one year after the date entered below** ☐ **will not expire**

_____ _____
Signature of Client (age 18 or older) Date

_____ _____
Signature of minor's custodial parent or legal guardian Date Witness Date

Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical information or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5000 in the case of each subsequent offense.

☐Mail ☐File ☐Send Records Date Sent_____ By _____