Patient Authorization to Disclose Protected Health Information (PHI)

Today's Date: _____ Date of Birth: _____ Last 4 of Soc Sec#: _____

Client Name: _____ Phone: _____

Address: _____ City,State,Zip: _____

I, the patient named above, hereby authorize:

Dr. Jeff Peterson, PhD, LCPC, LPC, NCC
Kansas City Psychotherapy
9233 Ward Parkway, Suite 305
Kansas City, MO 64114
(816) 866-5524
www.kcpsychotherapy.com
kcpsychotherapy@gmail.com

❑ to RECEIVE information contained in my medical records from:
Practitioner Name: _____ Address: _____

❑ to RELEASE information contained in my medical records to:
Practitioner Name: _____ Address: _____

For the following purpose(s):
- ❑ Further mental health evaluation, treatment, or care
- ❑ Treatment planning
- ❑ Other: _____

Type of Disclosure Authorized & Delivery Instructions: 1) Mail records directly to the address above (I do not send or receive records via FAX), 2) Please disclose my psychotherapy notes, and 3) I give consent to verbally discuss my PHI.

These records concern the treatment dates between _____ and _____.

This authorization is for (check only one - a separate release is required for each): ❑ Psychotherapy Notes ❑ Medical Records

Types of PHI to be released or received:

- ❑ Intake and discharge summaries _____
- ❑ Medical history and evaluation(s) _____
- ❑ Mental health evaluations _____
- ❑ Developmental and/or social history _____
- ❑ Educational records _____
- ❑ Treatment summary _____
- ❑ Other: _____

I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency virus (HIV). I give my consent to release these records unless indicated here:

❑ Do not release HIV-related information ❑ Do not release drug and alcohol information
❑ Do not release _____

I certify that this request is made voluntarily and that information given above is accurate to the best of my knowledge. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand that the facility will provide me a copy of the signed authorization form. I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. I understand that I may take back this consent at any time within 90 days by sending a written revocation to the address above, except to the extent that action based on this consent has already been taken. This authorization expires automatically after 90 days from the date on which it is signed.

_____ _____
Signature of client Date

_____ _____ _____ _____
Signature of parent/guardian/representative Guardian's Printed name Relationship Date

_____ Initials