Prairie View

Name:_____

Prairie View Case Number:_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's Printed Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

I Authorize Prairie View To: ☐ Release Information To: (and/or) ☐ Obtain Information From:

Agency/Organization: _____ Name: _____

Relationship to Patient: _____ Email: _____ Emergency Contact: ☐

Address: _____ City, State, Zip: _____

Phone: _____ Secondary Phone: _____ Fax: _____

Check all that apply:

- ☐ **Entire record** including correspondence and fee info
- ☐ **Mental Health Evaluation**
- ☐ **Medication Evaluation**
- ☐ **Substance Use Assessment/ASAM Update**
- ☐ **Progress notes** (last 6 months)
- ☐ **Medical notes** (last 6 months)
- ☐ **Treatment plan**
- ☐ **Discharge summary/plan**
- ☐ **Legal documents/reports**
- ☐ **Appointments/Scheduling /Attendance**
- ☐ **Medication list**
- ☐ **Lab results**
- ☐ **Psychiatric Residential Treatment Facility -** Turning Point
- ☐ **Sex offender assessment**
- ☐ **School records**
- ☐ **Psychological/Neuropsychologi -cal testing report**
- ☐ **Fee information**
- ☐ **Other:** _____

For the purpose of: ☐ Treatment, Payment and/or Healthcare Operations ☐ Other: _____

Expiration Date: _____ (one year from date signed if not otherwise specified)

I understand that my treatment will not be conditioned upon signing this authorization and that I have the right to revoke the authorization, except to the extent action has been taken or it has been relied on, by putting my revocation in writing and delivering it to Prairie View. I understand that information disclosed under the authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy rules. 42 CFR Part 2 prohibits unauthorized use or disclosure of these records. I understand that I will receive a copy of this authorization.

_____
Printed Name of Patient

_____
Signature of Patient

Date: _____ Time: _____

OR

_____
Printed Name of Representative

_____
Signature of Representative

_____
Description of Representative's Authority
(i.e. Legal Guardian or Durable Power of Attorney)

_____
Representative Address

_____
Prairie View Representative

Date: _____ Time: _____

_____
Phone

Date: _____ Time: _____

1901 E 1st St
Newton, KS 67114

508 S Ash
Hillsboro, KS 67063

1102 Hospital Dr
McPherson, KS 67460

7570 W 21st St N Ste 1026-D
Wichita, KS 67205