

Name: _____

Prairie View Case Number: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's Printed Name: _____

Address: _____

Date of Birth: _____

Purpose of Disclosure:

___ to coordinate treatment

___ at the request of the patient

___ other: _____

I authorize

Prairie View
1901 East First Street
PO Box 467
Newton, KS 67114

___ to exchange information with:

___ to disclose information to:

___ to obtain information from:

Name: _____

Address: _____

Phone: (home) _____

(cell) _____

(business/work) _____

Fax: _____

Relationship to patient: _____

Check appropriate blanks:

_____ **Hospital Inpatient** – psychiatric assessment, history & physical, lab, psychological testing report, discharge summary

_____ **Addictions Treatment Center** – psychiatric assessment, substance abuse assessment, history & physical, lab, psychological testing report, progress reports, discharge summary

_____ **Partial Hospital** – psychiatric assessment, discharge summary

_____ **Psychiatric Residential Treatment Facility** – psychiatric assessment, psychological testing report, discharge summary

_____ **Outpatient** – admission assessment, list of medications

_____ **School records** – school progress notes, school intake evaluation, grades, attendance, IEP

_____ **Treatment plan**

_____ **Psychiatric Assessment**

_____ **Psychological testing report**

_____ **Substance abuse assessment**

_____ **Sex offender assessment**

_____ **Therapy notes** (last 6 months)

_____ **Medication checks** (last 6 months)

_____ **Lab reports** (last 6 months)

_____ **Entire record** – including correspondence and fee information

_____ **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. I understand that I will receive a copy of this authorization.

Printed Name of Patient

Signature of Patient

Date: _____ Time: _____

I understand that by typing my name I am electronically signing this document.

Prairie View Representative

Date: _____ Time: _____

Printed Name of Representative

Signature of Representative

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

Address Line 1

Address Line 2

Phone: _____

Date: _____ Time: _____