Prairie View
Behavioral & Mental Healthcare

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:_____

_____

Email: _____

Phone: (home)_____

(cell)_____

(business/work)_____

Fax:_____

Relationship to patient:_____

Check appropriate blanks:

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

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

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

_____ **Outpatient** – admission assessment

_____ **School records** – school progress notes, school intake evaluation, grades, attendance, IEP, individual plan of study

_____ **Treatment plan**

_____ **Psychiatric Assessment –** list of medications

_____ **Psychological/Neuropsychological testing report**

_____ **Substance Use Assessment**

_____ **Sex offender assessment**

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

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

_____ **Fee information**

_____ **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:_____

_____
Prairie View Representative

Date:_____ Time:_____

OR

_____
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:_____