

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 _____ to exchange information with:
Prairie View _____ to disclose information to:
1901 East First Street _____ to obtain information from:
PO Box 467
Newton, KS 67114

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
- _____ **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)
- _____ **Entire record** – including correspondence and fee information
- _____ **Fee Record**
- _____ **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

Printed Name of Representative

Signature of Patient

OR

Signature of Representative

Date: _____ Time: _____

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

Address Line 1

Prairie View Representative

Address Line 2

Phone: _____

Date: _____ Time: _____

Date: _____ Time: _____