Responsive Centers for Psychology and Learning

7501 College Boulevard, Suite 250 Overland Park, KS 66210
Phone: (913) 451-8550 Fax: (913) 469-5266

Authorization for Release of Confidential Information

This form, when completed and signed by you, authorizes me to **release** and **receive** protected health information from your clinical record with the person or people you designate.

Patient Information:

Name: _____ Address: _____

Date of Birth: _____ _____

_____ _____
Parent of Minor Child

Phone: _____

Authorization for Release. I hereby authorized the exchange of information between the following parties:

_____ _____
Responsive Centers Name
7501 College Blvd, Suite 250 _____
Overland Park, KS 66210 Street Address

_____
City State Zip

_____ _____
Phone Fax

Specific Authorization. I specifically authorize the release and/or exchange of the following confidential information:
___ All records ___ Therapy records ___ Reports ___ Correspondence ___ Test results ___ Clinical observations
___ Billing information ___ Other (Please specify): _____

For the following reasons:
___ At the request of the individual ___ Treatment planning ___ Coordination of care ___ Change of therapist/educator
___ Forensic evaluation ___ Other (please specify): _____

Re-disclosure. This release does **NOT** authorize re-disclosure of confidential information beyond the limits of this consent except in the case of court ordered evaluations where the information may be disclosed to the court. The recipient of this information is **PROHIBITED** from using the information other than the stated purpose, and from disclosing to any other party without further authorization.

Validity. I understand that this authorization will automatically expire one year from the date of my signature. I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above.

I authorize the release of information as indicated above.

_____ _____
Signature by Patient or Parent/guardian Date

If authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided. (Parent of minor child, legal guardian, etc.)