Signature
PSYCHIATRIC HOSPITAL

AUTHORIZATION FOR ☐ RELEASE ☐ TO OBTAIN HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Current Phone Number:_____ Social Security Number:_____

I authorize **Signature Psychiatric Hospital, Health Center North, 2900 Clay Edwards Drive, Kansas City, MO 64116 ,** to ☐ release and/or ☐ obtain my health information for the purpose of continuity of care, payment, health care operations, or other as defined below:

_____.

To:_____

Name of designated individual, organization, or Provider

_____

Address Phone Fax

INFORMATION TO BE RELEASED:

- ☐ All Medical Records
- ☐ All Billing Records
- ☐ Psychiatric Evaluation
- ☐ Discharge Summary
- ☐ Lab
- ☐ History & Physical
- ☐ D/C Aftercare Plan
- ☐ Other_____

DATES OF TREATMENT:

- ☐ All Dates
- ☐ Specific Date(s):_____

_____

Other:_____

_____

1. I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.
3. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider.
4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
5. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

This authorization will expire 1 year from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Attorney or witness