Consent for Release of Health Information

I, _____, D.O.B _____, authorize and request:
Patient Full Name (Printed) Date of Birth

Release record to/from: Need complete name and address	Send records to/from: Need complete name and address
Rachael James, PMHNP	
8340 Mission Rd Ste 210	
Prairie Village, KS 66206	
Ph: (913) 642-0100	Ph:
Fax: (913) 642-0176	Fax:

Information to be released:

____Psychiatric Evaluation ____History and Physical

____EEG/EKG ____Complete Record

____Lab Results ____Other _____

Dates of Disclosure: _____

Purpose of disclosure: Continuation of treatment

Privacy Statement:
I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of any medical information requested to the agency or person specific above. Drug and alcohol abuse information records are specifically protected by federal regulations, and by signing this authorization I am allowing the release of any drug and/or alcohol information records to the agency or person specific above. I also understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it. This authorization expires one year after it is signed.

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR 2) prohibit you from making any further disclosure of these records without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

_____ _____
Signature of patient/parent or legal guardian/ Relationship to patient Date

_____ _____
Witness Date