

**Comprehensive Psychiatric Associates, L.L.C**  
**Authorization to Release/Obtain Protected Health Information**

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**The following individual/facility is authorized to make the disclosure described in this form:**

**Comprehensive Psychiatric Associates**  
**305 NW Englewood Court, Suite 300**  
**Gladstone, Missouri 64118**  
**(816) 453-7473**

**OR**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The information to be disclosed is:

Psychiatric Evaluation

Progress Notes

School/Teacher Information

Psychological Testing

Medication Record

Lab

Other: **Below** named person has my permission to make medication and diagnostic testing decisions, exchange verbal communication and participate in the treatment of the minor child listed at the top of this form as Patient.

**The purpose of the disclosure is: Release To/ Obtain From or Exchange Verbal Information**

The information is to be disclosed to:

Relationship to minor child:

Name: \_\_\_\_\_

Phone # (     ) \_\_\_\_\_

Address: \_\_\_\_\_

City

State

Zip:

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 specified above.

I understand that I may revoke this consent at any time, except to the extent that action based on the consent has already been taken. I may revoke this Authorization by submitting my revocation in writing to the Provider at the address stated above.

These records are to be released for the purpose stated above. This Authorization to release information from my records is fully understood as to the nature of the information from the records and the implications of its release and is made voluntarily on my part.

If the requester or receiver is not a health plan or healthcare provider, there is a potential for the information disclosed to be subject to redisclosure by the recipient and no longer protected by federal privacy regulations. CPA, LLC cannot be responsible for or protect any redisclosure.

This Authorization expires upon the following date or event: \_\_\_\_\_. If left blank, I agree that this Authorization shall be valid for a period of twelve (12) months from today's date.

I understand that I may see and obtain a copy of the information described on this form, for a reasonable fee, if I ask for it.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Parent/ Guardian to minor child

\_\_\_\_\_  
Signature of Witness / Notary

\_\_\_\_\_  
Date