

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 **OR** _____
(816) 453-7473 _____

The information to be disclosed is:

___ Psychiatric Evaluation ___ Progress Notes ___ School/Teacher Information
___ Psychological Testing ___ Medication Record ___ Lab
___ Other: _____

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

The information is to be disclosed to:

Name: _____ Please mail copies to the address indicated at left.

Phone # () _____

Address: _____ I am planning to pick up the copies. Please Call me when they have been copied.

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

Signature of Witness / Notary

Date