Comprehensive Psychiatric Associates, LLC
Authorization to Release/Obtain Protected Health Information
To/From a Non-Custodial Parent or Legal Guardian

Patient Name: _____ DOB: _____

Person Making Request: _____ Phone #: _____

Relationship to Patient: _____

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

Comprehensive Psychiatric Associates, LLC
305 NW Englewood Court, Suite 300
Gladstone, MO 64118
Office: (816) 453-7473

OR

_____
_____
_____

Information requested for release:

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

The purpose of the disclosure is: Exchange Verbal Information and Allow Participation in Patient's Treatment

The information is to be disclosed to:

Name: _____ **Relationship to:**

Phone #: _____ **Patient: _____**

Address: _____ **Person Making Request: _____**

City: _____ State: _____ Zip: _____

I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that the information in my minor child's medical records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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.
This authorization expires upon the following date: _____. If left blank, I agree that this authorization shall terminate upon the minor's age of majority unless revoked earlier.

I have read the information provided on this release and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
Signature of Parent/Legal Guardian Date

NOTICE OF REVOCATION – This revocation cancels my authorization given above.

_____ _____
Signature of Patient/Parent/Legal Guardian Date