Comprehensive Psychiatric Associates, LLC
305 NW Englewood Ct., Suite 300
Gladstone, MO 64118
Phone: (816) 453-7473
Fax: (816) 453-1940

Medical Record Release Authorization

Patient Name: _____ DOB: _____ Phone #:_____

Address_____City/State/Zip_____

Person making request: _____ Relationship to Patient:_____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone#_____Fax#_____

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone#_____FAX#_____

This information is requested for the purpose of: _____ Continuity of care _____ Legal proceedings ____ Disability Determinations

_____ Applications/reapplications of benefits _____ Other(specify)_____

Actions to be taken: ___Written & verbal information ____Written Information ONLY ____ Verbal Information ONLY

Information requested for release: _____ Progress Notes _____ Medication List _____ Labs _____ Form Completion

_____ Therapy Notes _____ Psych Evaluations _____ Hospital Records From:_____ To: _____

____ Letter re:_____ ____ Other _____

Is Fax Transmission Authorized ____ Yes ____ No

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. 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. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record 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 any time. 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 consent to release information will automatically terminate one year from the date signed unless I specify an expiration date of: _____, or revoke earlier.

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

_____ _____

Signature of Patient/Parent/Legal Representative Date

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

_____ _____

Signature of Patient/Parent/Legal Representative **Date Revocation Signed**

** **Please Read** Fee Information: Comprehensive Psychiatric Associates, LLC (CPA) contracts with DataFile Technologies to copy and provide medical records requested from our office. We reserve the right to charge the fee schedule as set by the State of Missouri. An invoice will be sent to you from CPA or DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay CPA or DataFile Technologies for your records. In case of continuity of care, we may transfer a minimal portion directly to a physician as a courtesy.