RESEARCH PSYCHIATRIC CENTER – FAX # (913)-339-9915
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: The undersigned hereby authorizes and requests (this section must be completed for all authorizations):

Patient Name:	**Birth Date:**	**Social Security No.** ***(last four digits only)*****:** XXX – XX –
Provider's Name: ***Mill Creek Clinic***	**Recipient's Name (whom information will be released to):X**	
Provider's Address: ***8787 Ballentine, Suite 1200 Overland Park, Kansas 66214***	**Address 1:**	
	Address 2:	
	City:	**State:** **Zip:**

This authorization will expire on: (Fill in the Date or the Event but not both-if left blank, this authorization expires in 90 days)
Date: **Event:**

Purpose of disclosure (description of purpose information to be used or disclosed):

For Mill Creek Outpatients only: Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Check the following items that you are requesting:

Description:	**Date(s):**	**Description:**	**Date(s):**	**Description:**	**Date(s):**
☐ Admission form		☐ Intake Assessments		☐ Patient Education Sheets	
☐ Dictated Psychiatric Exam		☐ Progress Notes		☐ Treatment Plans	
☐ Dictated History & Physical		☐ Special test/therapy		☐ Itemized bill	
☐ Physician orders		☐ ECT Strips		☐ UB-92	
☐ Discharge Summary		☐ Nursing Information		☐ All of the medical record	
☐ Clinical Test _____		☐ Transfer forms		☐ Entire designated record set	
☐ Medication Sheets		☐ ER Information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing? ☐ Yes ☐ No If yes, the health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? If yes, describe:	☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient, Guardian or Authorized representative:	**Date:**
Printed Name:	**Relationship to Patient/Plan Member:**

RESEARCH PSYCHIATRIC CENTER

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PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from the records protected by Federal Confidentiality Rules (42CFR part 2). This prohibits you from making further disclosure of it 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 information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 06/2011