Overland Park Location
8220 Travis St., Suite 205
Overland Park, KS 66204
Telephone 913-735-3348

--CONSENT/AUTHORIZATION to DISCLOSE HEALTH INFORMATION--

Patient Name:_____ Patient Date of Birth:_____
patient full name (first and last)

I hereby consent and authorize, True Course Counseling to Release/obtain/exchange mental health information and records obtained in the course of mental health treatment provided to the above patient, including but not limited to mental health diagnosis of the patient, to the following individual or organization:

Name:_____ Relationship to client: _____

Address:_____

Phone:_____ Fax:_____

Requested Information:

○ Intake/Discharge Treatment Summary ○ Full Chart ○ Lab Results ○ Phone consult

○ Billing/Scheduling Info ○ other_____

This information has been requested for the purpose of coordination of care or at the request of the above patient.

Requested Service Dates: Records released are limited to the past 2 years of information unless otherwise requested. Other requested dates from (M/Y):_____ To (M/Y):_____

I understand that if the information to be disclosed contains any of the types of records relating to mental health, genetic testing, drug/alcohol diagnosis, and HIV/AIDS, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I sign this form.

I understand that once the information is used or disclosed pursuant to this authorization it may be re-disclosed by the recipient and that Resolve Counseling and Wellness cannot guarantee the same stands of confidentiality or protection by state and federal privacy regulations. However, I also understand that federal or state law may restrict re-disclosure of any mental health, genetic testing, drug/alcohol diagnosis, and/or HIV/AIDS treatment or referral information.

Information about Revoking the Authorization: You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization, except for action already taken. To revoke this authorization, please send a written statement to Trie Course Counseling and state that you are revoking this authorization. Unless revoked earlier, this consent will expire **one year** from the date of signing.
REVOCATION (optional) - Date:_____ Event/Condition:_____ Signature:_____

Refusal to sign this authorization will not adversely affect your ability to receive emergency health care services. Refusal to sign will lead to your not receiving health care services if health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

I have read this authorization and I understand it _____ _____
(Date) (Signature of Patient or Persons Authorized by Law)