THE THERAPY CENTER
Solutions for peace of mind.

7807 E Funston
Wichita, KS 67207
316-636-1188

Consent For The Release Of Confidential Information

Patient Name: _____ Patient DOB: _____

I authorize and request _____
(Provider Name)

To exchange information with:

_____ _____
(Name) (Address and/or Fax)

The following information:

_____ Dates & Times of Service _____ Discharge Summary _____ Court Records
_____ Psychological Evaluation _____ Treatment Records _____ School Records
_____ Insurance/Billing
_____ Other (*specify*) _____

The purpose and reason for disclosure:

_____ Assist in Treatment Planning _____ Advise the Court _____Transfer/Referral
_____ Complete Evaluation _____ Coordinate Treatment
_____ Other (*specify*) _____

Medical records are protected by Federal Regulations, Kansas Statues and/or Administrative Regulations re-disclosure is prohibited, Federal Regulation 42 C. F. R. Part 2 prohibits any further disclosure of this information, except with specific written consent of the person to whom it pertains.

I understand that I may revoke this consent to release information at any time except to the extent that action has been taken or information disclosed pursuant to the signed consent. I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above. This consent is effective until rescinded by the above-named client in writing.

_____ _____
Signature of Patient Date

_____ _____
Parent/Legal Guardian/Authorized Person Date

_____
Relationship to Patient