FLINT HILLS
neuropsychology

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**AUTHORIZATION FOR RELEASE OF HEALTH CARE RECORDS**

Patient Name _____ Date of Birth _____

I authorize Flint Hills Neuropsychology to RELEASE / REQUEST information TO / FROM:

Name: _____ Phone _____

Address:_____

Dates of Treatment: _____

Information to be released: _____

Purpose of disclosure: _____

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by written notification, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal privacy regulations.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
5. I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent of Minor/Legal Guardian Date

_____
Relationship to Patient