

Patient Guide

Authorization to Release Information

<u>Patient Information</u> Please Print Legibly OR Place Patient Identifying Label	<hr/> Patient Legal Name <hr/> Date of Birth	
<u>Health Care Provider, Person, or Agency</u> <i>With Whom may PrairieCare and its affiliates share/receive my information or my child's information?</i>	<hr/> Physician(s), Provider(s), or Person(s) Agency or Clinic <hr/> Relationship to Patient Phone Number <hr/> Address (street, city, state, zip code) Fax Number	
<u>Communication</u> Please check all that apply <i>How will PrairieCare share/receive my information?</i>	<u>Direction:</u> <input type="checkbox"/> Exchange the information indicated below <input type="checkbox"/> Receive the information indicated below <input type="checkbox"/> Release the information indicated below	<u>Method:</u> <input type="checkbox"/> Written Communication (Fax, Mail, Secured Email) <input type="checkbox"/> Verbal communication
<u>Information to be Released:</u> Please mark all that apply. <i>What is to be released?</i>	<u>Requires Patient (16 years or older) OR Parent/Guardian consent:</u> <input type="checkbox"/> Acknowledgement of Patient's Access of Service <input type="checkbox"/> Discharge Summaries & Plans <input type="checkbox"/> Diagnostic Assessments <input type="checkbox"/> Progress in Treatment <input type="checkbox"/> Treatment Plans <input type="checkbox"/> Psychological Consult/Testing <input type="checkbox"/> Medical Consults/History & Physical <input type="checkbox"/> ALL RECORDS (Including All Items listed above) <input type="checkbox"/> Other:	<u>Requires Patient consent, regardless of age, as evidenced by Patient's Initials:</u> <input type="checkbox"/> Chemical Use & Abuse Assessment, Data, and Information <input type="checkbox"/> Reproductive and Sexual Health Information <input type="checkbox"/> Lab Results Regarding Chemical Use or Reproductive Health, including HIV/AIDS Information <i>Please note that CD/Alcohol information and Reproductive Health Information (including lab results) contained in any records will be redacted prior to sending unless the patient has initialed the above items.</i>
<u>Purpose of the Release of Information</u> <i>Why is the release needed?</i>	<input type="checkbox"/> Assessment & Treatment <input type="checkbox"/> Insurance Purposes <input type="checkbox"/> Psychological Evaluation/Testing <input type="checkbox"/> Legal <input type="checkbox"/> Coordination of Care/Follow Up <input type="checkbox"/> Education <input type="checkbox"/> Acknowledgement of Patient's Access of Service/Referral <input type="checkbox"/> Discharge Planning <input type="checkbox"/> <u>Other (must specify):</u>	
<u>Statement of Authorization:</u> Please Review Terms and Conditions to Agreement <i>What is my signature authorizing?</i>	- I understand that I may revoke this authorization at any time, except to the extent that previous action has been taken in reliance of the Authorization for Release of Information. (Please refer to PrairieCare's Notice of Privacy Practices for instructions on how to revoke authorizations or to inspect and/or receive copies of this information.) - A photocopy, electronic version, or fax of this authorization will be treated in the same way as the original. - My signature means that I have read this form and/or have had it read to me and explained in a language that I can understand. - Authorizing the disclosure of this information is voluntary, and I can refuse to sign this authorization without consequence to my treatment, eligibility for benefits, or payment status. - Once authorized information is released, PrairieCare, its employees, and its physicians cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent, and any re-disclosure of that information. -I understand that this authorization remains in effect for one year from the date of signature, or: <hr/> (Specify date, event, or conditions that cause authorization to expire.)	

Signature of Patient (Patients 16 and older must personally consent for all mental health records.)

Date

Signature of Parent/Guardian

Relationship to Patient

Date