PrairieCare

Patient Guide

Authorization to Release Information

<table>
<tr><td><u>Patient Information</u>
Please Print Legibly
OR
Place Patient Identifying Label</td><td colspan="2">______________________________
Patient Legal Name
____
Date of Birth</td></tr>
<tr><td><u>Health Care Provider, Person, or Agency</u>
With Whom may PrairieCare and its affiliates share/receive my information or my child's information?</td><td colspan="2">______________________________
Physician(s), Provider(s), or Person(s) Agency or Clinic
____
Relationship to Patient Phone Number
____
Address (street, city, state, zip code) Fax Number</td></tr>
<tr><td><u>Communication</u>
Please check all that apply
How will PrairieCare share/receive my information?</td><td>Direction:
____ Exchange the information indicated below
____ Receive the information indicated below
____ Release the information indicated below</td><td>Method:
____ Written Communication (Fax, Mail, Secured Email)
____ Verbal communication</td></tr>
<tr><td><u>Information to be Released:</u>
Please mark all that apply.
What is to be released?</td><td>Requires Patient (16 years or older) OR Parent/Guardian consent:
____ Acknowledgement of Patient's Access of Service
____ Discharge Summaries & Plans
____ Diagnostic Assessments
____ Progress in Treatment
____ Treatment Plans
____ Psychological Consult/Testing
____ Medical Consults/History & Physical
____ ALL RECORDS (Including All Items listed above)
____ Other:</td><td>Requires Patient consent, regardless of age, as evidenced by Patient's Initials:
____ Chemical Use & Abuse Assessment, Data, and Information
____ Reproductive and Sexual Health Information
____ Lab Results Regarding Chemical Use or Reproductive Health, including HIV/AIDS Information
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.</td></tr>
<tr><td><u>Purpose of the Release of Information</u>
Why is the release needed?</td><td>____ Assessment & Treatment
____ Psychological Evaluation/Testing
____ Coordination of Care/Follow Up
____ Acknowledgement of Patient's Access of Service/Referral</td><td>____ Insurance Purposes
____ Legal
____ Education
____ Discharge Planning
____ Other (must specify):____________</td></tr>
<tr><td><u>Statement of Authorization:</u>
Please Review Terms and Conditions to Agreement
What is my signature authorizing?</td><td colspan="2">- 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:
____
(Specify date, event, or conditions that cause authorization to expire.)</td></tr>
</table>

____

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

____

Signature of Parent/Guardian Relationship to Patient Date