***If you would like me to communicate with someone about you, please complete:***

**Authorization for the Release of Confidential Information**

This form when completed and signed by you authorizes Maria Ilardi, APRN to share protected clinical information by:

\_\_\_ Exchange of information with \_\_\_ Release of information to \_\_ Requesting information from

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_, authorize

Name of Client or Legal Guardian

Maria Ilardi, APRN

1311 Wakarusa Drive, Suite 2117

Lawrence, KS 66049

Phone: 785-312-9866 fax: 785-246-5747, To exchange information with

Name of Person/ Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information will include: (*please check each item to be disclosed)*

\_\_\_\_ Assessments \_\_\_\_ Testing/Lab results

\_\_\_\_ Medication records \_\_\_\_ History and Physical

\_\_\_\_ Treatment plan or summary \_\_\_\_ Demographic Information

\_\_\_\_ Discharge/Transfer summary \_\_\_\_ Presence in Treatment

\_\_\_\_ Progress Notes \_\_\_\_ Billing information only

\_\_\_\_ ER records \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization will remain in effect until I revoke the authorization.

I understand that my medical records may include HIV, psychiatric, and alcohol or drug abuse information. Federal regulations prohibit the recipient of the information from making further disclosure without the specific, written consent of the responsible person, or as otherwise permitted by law or regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. In the event that the person/entity who receives this information is not covered by the federal privacy regulations the information described above may be redisclosed and no longer protected by federal regulations.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that action has already been taken on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Signature of Patient or legal guardian Date

Signature of Witness Date