Prairie View
Behavioral & Mental Healthcare

Name:_____

Prairie View Case Number:_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's Printed Name: _____

Address: _____

_____

Date of Birth: _____

Purpose of Disclosure:

☐ to coordinate treatment

☐ at the request of the patient

☑ other: apply for CDDO services

I authorize

Prairie View
1901 East First Street
PO Box 467
Newton, KS 67114

☑ to exchange information with:

☑ to disclose information to:

☐ to obtain information from:

Name: Harvey-Marion County CDDO

Address: 500 N. Main Street

Suite #204

Newton KS 67114

Phone: (home)_____

(cell)_____

(business/work) (316) 283-7997

Fax: (316) 283-7969

Check appropriate blanks:

☐ **Hospital Inpatient** – psychiatric assessment, history & physical, lab, psychological testing report, discharge summary

☐ **Addictions Inpatient** – psychiatric assessment, substance abuse assessment, history & physical, lab, psychological testing report, progress reports, discharge summary

☐ **Partial Hospital** – psychiatric assessment, discharge summary

☐ **Psychiatric Residential Treatment Facility** – psychiatric assessment, psychological testing report, discharge summary

☐ **Outpatient** – admission assessment, list of medications

☐ **School records** – school progress notes, school intake evaluation, grades, attendance, IEP

☑ **Treatment plan**

☐ **Psychiatric Assessment**

☐ **Psychological testing report**

☐ **Substance abuse assessment**

☐ **Sex offender assessment**

☐ **Therapy notes** (last 6 months)

☐ **Medication checks** (last 6 months)

☐ **Lab reports** (last 6 months)

☐ **Entire** record – including correspondence and fee information

☑ **Other**: Neuropsychological evaluation

Expiration Date:_____ (one year from date signed if not otherwise specified)

I understand that my treatment will not be conditioned upon signing this authorization and that I have the right to revoke the authorization, except to the extent action has been taken or it has been relied on, by putting my revocation in writing and delivering it to Prairie View. I understand that information disclosed under the authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy rules. I understand that I will receive a copy of this authorization.

_____
Printed Name of Patient

_____
Signature of Patient

Date:_____ Time:_____

_____
Prairie View Representative

Date:_____ Time:_____

OR

_____
Printed Name of Representative

_____
Signature of Representative

_____
Description of Representative's Authority
(i.e. Legal Guardian or Durable Power of Attorney)

_____
Address Line 1

_____
Address Line 2

Phone:_____

Date:_____ Time:_____