Authorization to Release/Obtain Protected Health Information To/From a Non-Custodial Parent or Legal Guardian

Patient Name: _____ DOB: _____

Person Making Request: _____ Phone #: _____

Relationship to Patient: _____

The following individual/facility is authorized to make the disclosure described in this form:

Liberty Psychological Services
Rebecca Morris, Ph.D.
6 Victory Ln, Ste 120
Liberty, MO 64068
Phone: (816) 407-9225
Fax: (816) 734-0083

OR

_____
_____
_____
_____

Information requested for release:

__X__ Other: **Below name person has my permission to make medication and diagnostic testing decisions, exchange verbal communication and participate in the medical/therapy treatment of the minor child listed at the top of this form as Patient.**

The purpose of the disclosure is: Exchange Verbal Information and Allow Participation in Patient's Treatment

The information is to be disclosed to:

Name: _____
Phone #: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____

Relationship to:
Patient: _____
Person Making Request: _____

I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that the information in my minor child's medical records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
This authorization expires upon the following date: _____. If left blank, I agree that this authorization shall terminate upon the minor's age of majority unless revoked earlier.

I have read the information provided on this release and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
Signature of Parent/Legal Guardian Date

NOTICE OF REVOCATION – This revocation cancels my authorization given above.

_____ _____
Signature of Patient/Parent/Legal Guardian Date