

Liberty Psychological Services
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Medical Record Release Authorization

Patient Name: _____ DOB: _____ Phone #: _____

Address _____ City/State/Zip _____

Person making request: _____ Relationship to Patient: _____

A) I hereby authorize records FROM:

B) To be released TO:

Name _____

Name _____

Address _____

Address _____

City/State/Zip _____

City/State/Zip _____

Phone# _____ Fax# _____

Phone# _____ FAX# _____

This information is requested for the purpose of: _____ Continuity of care _____ Legal proceedings _____ Disability Determinations
_____ Applications/reapplications of benefits _____ Other(specify) _____

Actions to be taken: _____ Written & verbal information _____ Written Information ONLY _____ Verbal Information ONLY

Information requested for release: _____ Progress Notes _____ Medication List _____ Labs _____ Form Completion

_____ Therapy Notes _____ Psych Evaluations _____ Hospital Records From: _____ To: _____

_____ Letter re: _____ Other _____

Is Fax Transmission Authorized _____ Yes _____ No

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. 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. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record 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 any time. 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 consent to release information will automatically terminate one year from the date signed unless I specify an expiration date of: _____, or revoke earlier.

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

Signature of Patient/Parent/Legal Representative

Date

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

Signature of Patient/Parent/Legal Representative

Date Revocation Signed