White Oak Psychiatric Services

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize:

White Oak Psychiatric Services
4045 NE Lakewood Way, Ste 130
Lee's Summit, MO 64064
Fax: 816-886-2397

A valid street mailing address is required to send records.

☐ Receive from: _____

_____
Fax Number

☐ Disclose to: _____
Address: _____
_____
_____
Fax Number

The following information regarding my outpatient care on _____
Specify dates of clinic visits

Please Check:

- ☐ Complete Medical Records
- ☐ Complete Mental Health Records
- ☐ Hospital Discharge Summary
- ☐ Consultations
- ☐ History and Physical Examinations
- ☐ Records from Other Providers (please specify) _____
- ☐ Other (please specify _____
- ☐ X-Ray, Imaging Reports
- ☐ Laboratory Reports
- ☐ Cardiac/EKG Reports

The purpose for disclosing the above information is indicated by a check mark below:

☐ Continuing Care ☐ Relocation ☐ Insurance ☐ Legal ☐Other _____

I understand that I have no obligation to disclose information from my records and that I may revoke this authorization by submitting a request in writing along with a copy of this form to the practice manager of this office. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

The signing of this authorization is not a condition for providing treatment.

I understand that if the organization authorized to receive the information is not a health plan or health care Provider; the information may be re-disclosed and no longer be protected by federal privacy regulations. However, certain protected records such as drug and/or alcohol use, abuse, treatment, or referrals for treatment, HIV information; and mental health services may not be re-disclosed per state laws and regulations and/or Federal confidentiality rules.

My signature acknowledges that I have read and understand the contents of this authorization and voluntarily consent to the release of information as stated including release of any records identified below unless I check here to not disclose such records. Checking or not checking the box is no indication that such information exists. Records **NOT** to disclose:

☐ HIV information ☐ Mental health services ☐Drug and/or alcohol use, abuse, treatment, or referrals for treatment.

My signature also acknowledges receiving a copy of the document.

THIS AUTHORIZATION SHALL EXPIRE 12 MONTHS FROM THE DATE EXECUTED UNLESS OTHERWISE SPECIFIED BY THE PATIENT:

_____ Print Patient's Full Name
_____ Signature of Patient/Responsible Party
_____ Date
_____ Patient's Date of Birth
_____ Relationship to Patient
_____ Patient's Social Security Number
_____ Witness Signature
_____ Date

NOTE: This authorization will not be accepted unless it is completed in its entirety.