Kids Inc. KC

A Safe Space for Healing

Authorization to Obtain or Release Confidential Records and Information

Client Name: _____ Date of Birth: _____

I hereby authorize the following person or agency to share written and oral information (two-way or reciprocal release) about my needs and the services I receive:

Name(s) (i.e. counselor/teacher): _____

Facility (i.e. school/office/hospital): _____

Address: _____

Zip: _____

Phone: _____ Email: _____

With (name of therapist) _____

The information shared or released is for the following purpose(s):

____ Further mental health evaluation, treatment, or care ____ Educational Program Planning

These records concern the time between _____ and _____.

The information to be disclosed is marked by an X in the boxes below, and the items not to be released have a line drawn through them.

____ Medical history and evaluation(s) ____ Mental health evaluations

____ Developmental and/or social history ____ Educational records

____ Treatment history Other:_____

My signature below acknowledges my understanding of the following:

I understand I am authorizing the release of confidential records and information. I understand their content and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may revoke my consent at any time within 90 days except to the extent that action based on this consent has already been taken. I understand that I have the right to receive a copy of this Release and to request to view the information released by this consent.

This consent will expire automatically after 360 days from the date on which it is signed, or upon fulfillment of response from above named facility or person(s) for the purposes stated above.

_____ _____ _____

Signature Printed name Date

_____

Relationship to Client

Confidential Exchange Of Information with
Primary Care Physician or other Behavioral Health Clinician/Facility