PrairieCare

Clear Form

Patient Guide

Authorization to Release Information

Patient Information Please Print Legibly OR Place Patient Identifying Label	_____ Patient Legal Name _____ Date of Birth
Health Care Provider, Person, or Agency *With **Whom** may PrairieCare and its affiliates share/receive my information or my child's information?*	_____ Physician(s), Provider(s), or Person(s) Agency or Clinic _____ Relationship to Patient Phone Number _____ Address (street, city, state, zip code) Fax Number
Communication Please check all that apply *How will PrairieCare share/receive my information?*	**Direction:** Exchange the information indicated below ____ Receive the information indicated below Release the information indicated below **Method:** Written Communication (Fax, Mail, Secured Email) ____ Verbal communication _____
Information to be Released: Please mark all that apply. *What is to be released?*	**Requires Patient (16 years or older) OR Parent/Guardian consent:** Acknowledgement of Patient's Access of Service Discharge Summaries & Plans Diagnostic Assessments Progress in Treatment Treatment Plans Psychological Consult/Testing ____ Medical Consults/History & Physical ____ **ALL RECORDS (Including *All Items* listed above)** ____ Other: _____ **Requires Patient consent, *regardless of age*, as evidenced by Patient's Initials:** ____ Chemical Use & Abuse Assessment, Data, and Information ____ Reproductive and Sexual Health Information ____ Lab Results Regarding Chemical Use or Reproductive Health, including HIV/AIDS Information ***Please note that CD/Alcohol information and Reproductive Health Information (including lab results) contained in any records will be redacted prior to sending unless the patient has initialed the above items.***
Purpose of the Release of Information *Why is the release needed?*	____ Assessment & Treatment ____ Psychological Evaluation/Testing ____ Coordination of Care/Follow Up ____ Acknowledgement of Patient's Access of Service/Referral ____ Insurance Purposes ____ Legal ____ Education ____ Discharge Planning ____ Other (must specify):_____
Statement of Authorization: Please Review Terms and Conditions to Agreement *What is my signature authorizing?*	- I understand that I may revoke this authorization at any time, except to the extent that previous action has been taken in reliance of the Authorization for Release of Information. (Please refer to PrairieCare's **Notice of Privacy Practices** for instructions on how to revoke authorizations or to inspect and/or receive copies of this information.) - A photocopy, electronic version, or fax of this authorization will be treated in the same way as the original. - My signature means that I have read this form and/or have had it read to me and explained in a language that I can understand. - Authorizing the disclosure of this information is voluntary, and I can refuse to sign this authorization without consequence to my treatment, eligibility for benefits, or payment status. - Once authorized information is released, PrairieCare, its employees, and its physicians cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent, and any re-disclosure of that information. -I understand that this authorization remains in effect for one year from the date of signature, or: _____ (Specify date, event, or conditions that cause authorization to expire.)

_____

Signature of Patient *(Patients 16 and older must personally consent for all mental health records.)* Date

_____

Signature of Parent/Guardian Relationship to Patient Date