Children's Mercy

Authorization for Release of Behavioral Health Information

8071-171 MR 09/12

Patient's Full Name and Previous Names Used _____ Date of Birth ___/___/___ Medical Record Number _____

Street Address _____ City _____ State _____ Zip Code _____

Information Requested to be Released by The Children's Mercy Hospital (CMH) – Check all that apply:

☐ Behavioral health information for the following dates:

___/___/___ ___/___/___ ___/___/___ ___/___/___

☐ Behavioral health information for the following date range: _____

Purpose of Release – Check and complete all that apply:

☐ Doctor appointment on (date): ___/___/___ Location: _____

☐ Other ongoing treatment or care: _____

☐ Other: _____

CMH will provide the information requested above to the following party – Check and complete all that apply:

Organization: _____ Telephone Number: (___) ___–_____

Attention: _____ Fax Number: (___) ___–_____

Email address: _____

Street Address _____ City _____ State _____ Zip Code _____

Release information by: ☐ Mail delivery ☐ Pick up ☐ CD/DVD, if available ☐ Encrypted Email, if available

I authorize the use or disclosure of information specified in this authorization regarding the patient named above. I understand that I have the right to revoke this authorization at any time, except when actions have already been taken on the basis of this authorization. To revoke this authorization, I must provide written notice to the Health Information Management department of The Children's Mercy Hospital or to the other organization named. Unless this authorization is revoked, it will expire once the disclosure is complete.

I do not need to sign a specific authorization to disclose information for treatment, payment or health care operations. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or have copied the information to be used or disclosed. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protections, then such information may be re-disclosed and would no longer be considered protected. If I have questions about disclosure of my information, I can contact the Health Information Management department of The Children's Mercy Hospital at (816) 234-3455.

Printed Name of Patient, Parent, or Legal Guardian _____ Relationship to Patient _____ (___) ___–_____ Telephone Number

Signature of Patient, Parent, or Legal Guardian _____ ___/___/___ Date

Street Address (if different from above) _____ City _____ State _____ Zip Code _____