James P. McHugh, Ph.D.
Authorization Form

(This form, when completed and signed by you, authorizes your mental health professional to release protected information from your clinical record to the person you designate; if you check "exchange," it also authorizes the designated party to provide information back to your mental health professional)

I authorize, _____and/or his or her administrative staff to

❑ Release ❑ Exchange

the following information:

_____

Specify the information to be disclosed:

_____

My **Protected Health Information (PHI)** should only be released to or exchanged with:

_____

Name

_____

Address

_____

I am requesting that this information be disclosed for the following reasons: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)

_____

This authorization shall remain in effect until: _____

I understand that my mental health professional generally may not condition health care services upon my signing an authorization unless the health care services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Note: You have the right to revoke this authorization, in writing, at any time by sending such written notification to Johnson County Psychiatric Services, 4707 College Blvd. Suite 210, Leawood, Kansas 66211. However, your revocation will not be effective to the extent that action has already been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent, Guardian or Legal Representative Relationship to Patient