

Two Rivers Behavioral Health System

PATIENT CONSENT/AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Once the requested Protected Health Information (PHI) is disclosed, the Privacy Regulations may no longer protect this information if the PHI recipient elects to redisclose the PHI.

I _____ of _____
Patient Name Address

Born _____ hereby authorize, request, and direct:

Date

(Facility closed 2/2019 - Medical Records Requests now processed by UHS-NRO Office in Nashville TN)

1000 Health Park Drive, Building 3, Suite 300, Brentwood, TN 37027 | P: 615-312-5834 | Fax: 615-997-1200

TWO RIVERS BEHAVIORAL HEALTH SYSTEM, 5121 Raytown Rd Kansas City, Missouri 64133

PHONE NUMBER: 615-312-5834

MEDICAL RECORDS FAX NUMBER: 615-997-1200

To: ☐ Disclose to ☐ Receive from:

Name of Person or Organization

Phone Number

Fax Number

Address of Person or Organization

The following information from my medical record relative to treatment I received from:

Date Range - From _____ To _____

PLEASE CHECK REQUESTED ITEMS:

- | | | |
|--|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Consultation Reports | |
| <input type="checkbox"/> Discharge/Aftercare Plan | <input type="checkbox"/> Intake Assessment | |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Social History Assessment | |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Treatment Plan | |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Laboratory Data | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> Insurance and Demographic Information | | <input type="checkbox"/> Verbal Communication with: _____ |
| <input type="checkbox"/> Other: _____ | | |

This information is released for the following purpose and that purpose only. No other use or further disclosure of such information is permitted.

Purpose of Disclosure (circle one):

Self
Therapist
School: _____

Social Security
Doctor
Family: _____

Legal
DFS/DYS
Other: _____

Insurance
Hospital

I understand my medical records (including alcohol/drug abuse information) may be protected by Federal Regulations.

This consent to disclose medical record information may be revoked at any time except to the extent that action has been taken in reliance thereon. This consent (unless expressly revoked in writing earlier) shall expire within 60 days.

Signature of Patient

Date

Signature of Parent, legal guardian, authorized representative

Date

Signature of Witness

Date/Time

FAXED

Date: _____

Signature: _____

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immune deficiency virus (HIV), and alcohol and drug abuse.

I authorize the release or disclosure of this type of information. _____ Signature of Patient.

DOC: AUTHORIZATION TO RELEASE INFORMATION TR1J 02012014