Patient:_____

Date:_____

Release of Information

(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.)

I authorize my mental health professional, Kelly Dawson, LSCSW, ____**to release** ___ **to obtain from** and / or ____**to exchange information with** the following individual and their staff or agency.

_____
Name

_____
Address

_____
City, State & Zip Code

_____
Telephone Number Fax Number

*Communication will be face-to-face, using phone, fax, mail, hand delivery and/or internet. Privacy statements will accompany all written communication using fax or internet.

Specify Information to Be Disclosed: _____

I am requesting that my mental health professional release this information for the following reasons: ("at the request of the individual and/or parent" is all that is required if you are my patient and you do not desire to state a specific purpose.) **Continuity of patient care**.

This authorization shall remain in effect for one year from today's date or until the date specified:
Until termination of treatment or notified in writing.

I understand that my treatment generally is not contingent upon my signing an authorization unless the 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: Kelly Dawson, LSCSW // 8700 Indian Creek Pkwy, Suite 220, Overland Park, KS. 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/Guardian ***Date***

Kelly Dawson, LSCSW | 8700 Indian Creek Pkwy, Suite 220 Overland Park, KS 66210
kellyclinnan@gmail.com | 913-302-8181