MALLORY BAUM, **LCMFT**
MYRANDA CONLEY, **LCPC, CPT**
KELCI FAGAN, **LMSW**
CINDY GEORGE, LCMFT, **TF-CBT**
ASHLEY KEEFOVER, **LPC**
ERIKA LEWIS, **LPC-T**
ANGELA MCGHEE, **LMSW**
AMY MEEK, **LCMFT-S, RPT-S**
BAILEY MITCHELL, **LCMFT, CST**
LYNDI STOKES, **LSCSW**

Authorization for Requesting and Disclosing Protected Health Information

Name:____ DOB:________________________

I hereby authorize Amy Meek Family Therapy Group: Provider:____

to:

☐Disclose information to ☐Request information from ☐Exchange information with (obtain and/or disclose)

Name (Person/ Agency Disclosing/ Requesting Info):____
Address:_________________________________City:________________ State:________ Zip:__________
Phone (optional):_____________ Fax (optional):_______________

Check specific information being authorized to be released or obtained:

☐Complete Record ☐Summary Diagnosis
☐Treatment Plan ☐Report of Progress/ Completion
☐Other:________________________________ ☐Consultation
☐Assessment/ Testing Evaluation ☐Discharge Summary

All of the records authorized above may be requested or disclosed unless restrictions are specified here:______________
____

I understand that this information will be used for the purpose of:
☐Evaluation/ Treatment ☐Case Coordination ☐Other:____________________

I understand that my records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA Confidentiality and Alcohol and Drug Abuse Patient Records, 42 CFR Part-2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization and must do so in writing and present this written revocation to Amy Meek Family Therapy Group. I understand that once information is disclosed per my authorization, the information may be redisclosed by the recipient in accordance with applicable laws and regulations and it may not be protected by federal or state privacy regulations.

I understand **AMFT Group will charge fees for reports and may charge fees to provide copies of records** and will apply guidelines and fee schedules established for compliance with the Kansas Open Records Act for this purpose.

____ ____________________
Signature of Patient/ Legal Guardian Date

____
Printed Name and Relationship