Amy Meek Family Therapy Group
Child, Adolescent, & Adult Therapy
316.788.6464ph/ 316.215.6588 fax

Mallory Baum, LCMFT
Cindy George, LMFT
Amy Meek, LCMFT
Bailey Mitchell, LMFT
Lana Secrest, LSCSW

Authorization for Requesting and Disclosing Protected Health Information

Name:____ DOB:______________

I hereby authorize Amy Meek Family Therapy Group
☐Mallory Baum, LCMFT ☐Cindy George, LMFT ☐Amy Meek, LCMFT ☐Bailey Mitchell, LMFT ☐Lana Secrest, LSCSW to:
☐Disclose information to ☐Request information from ☐Exchange information with (obtain and/or disclose)

Name (include relationship to patient if a person is listed):____
Address:_________________________________City:_______________ State:________ Zip:__________
Phone (optional):____________ Fax (optional):______________

Check specific information being authorized to be released or obtained:

☐Complete Record
☐Treatment Plan
☐Other:_________________________________
☐Assessment/ Testing Evaluation
☐Summary Diagnosis
☐Report of Progress/ Completion
☐Consultation
☐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. Unless otherwise revoked, this consent expires in 12 months from this date. 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

1415 N. Buckner, Derby, KS 67037