



*Amy Meek Family Therapy Group
Child, Adolescent, & Adult Therapy
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*Mallory Baum, LCMFT
Danika Drake, LMFT
Cindy George, LCMFT, TF-CBT
Amy Meek, LCMFT, RPT-S
Bailey Mitchell, LMFT
Lana Secrest, LSCSW, CPT*

Authorization for Requesting and Disclosing Protected Health Information

Name: _____ DOB: _____

I hereby authorize Amy Meek Family Therapy Group Danika Drake, LMFT Lana Secrest, LSCSW, CPT
 Mallory Baum, LCMFT Cindy George, LCMFT, TF-CBT Amy Meek, LCMFT Bailey Mitchell, LMFT 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:

- | | |
|---|---|
| <input type="checkbox"/> Complete Record | <input type="checkbox"/> Summary Diagnosis |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Report of Progress/ Completion |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Assessment/ Testing Evaluation | <input type="checkbox"/> 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