MALLORY BAUM, LCMFT
DANIKA DRAKE, LCMFT
DAISY DUNCAN-LITTLE, LPC, CPT
CINDY GEORGE, LCMFT, TF-CBT
AMY MEEK, LCMFT-S, RPT-S
BAILEY MITCHELL, LCMFT
JACOB MIZELL, LMSW
LANA SECREST, LSCSW, CPT, CCATP-CA

Authorization for Requesting and Disclosing Protected Health Information

Name: _____ DOB: _____

I hereby authorize Amy Meek Family Therapy Group: ☐Mallory Baum, LCMFT ☐Daisy Duncan-Little, LPC ☐ Cindy George, LCMFT ☐ Amy Meek, LCMFT-S ☐ Bailey Mitchell, LCMFT ☐ Jacob Mizell, LMSW ☐ Lana Secrest, LSCSW 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
☐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