Angie Lynn, LSCSW, RPT-S
Licensed Specialist Clinical Social Worker
Registered Play Therapist - Supervisor

Authorization to Release Information

I,______________________________, authorize Angie Lynn, LSCSW to

____ Disclose information to ____ Request information from ____ Exchange information with

Name:
Address:
City: **State:** **Zip:**
Phone No: **Fax No:**

Initial authorized information to be disclosed/requested/exchanged:

____ Admission Intake
____ Discharge Summary
____ Psychological Evaluation Report
____ Psychiatric Evaluation Report
____ Substance Abuse Report
____ Entire Record
____ Other:
____ Medical History, Lab Results
____ Diagnosis
____ Treatment Plan
____ Summary of Treatment
____ Progress Notes
____ Verbal or Written Progress Reports/Consultation

Purpose of Disclosure(s): _____ Comply with court order _____ Treatment of patient
_____ Response to referral source _____ Other: ________________________

This consent can be canceled in writing at any time. When a client/legal guardian revokes consent, Angie Lynn, LSCSW, is not liable for items sent after the consent is signed but before the cancellation of consent is received in our office. This consent is effective until 90 days after treatment ends. Information which has the potential to be harmful to the client may not be disclosed.

Treatment is not conditioned upon the execution of this authorization. Assurance cannot be given that the recipient will maintain confidentiality of this information being authorized to be released. A fee may be charged to provide copies of records. Guidelines and fee schedules established for compliance with the Kansas Open Records Act will be applied for this purpose.

Signature below indicates that this document has been read and authorization has been given for the disclosure of Protected Health Information as described. Records which include information about substance abuse require client signature even if that client is a minor.

When sending information, send to the attention of:

Angie Lynn, LSCSW
123 North Tyler, Suite 300
Wichita, Kansas 67212

____
Patient Printed Name

____
Patient Signature (16 and over)

____
Signature of Parent or Guardian of Patient

____
Parent or Guardian of Patient Address

____
City State Zip

____
Patient Address

____
City State Zip

____
Patient Social Security Number Date of Birth

____
Date

____
Witness