CONSENT FOR MEDICAL RECORD RELEASE & AUTHORIZATION FOR DISCLOSURE

Client Consent to Exchange Information with My Primary Care Physician, Therapist or other Specialist. HIPAA policy allows collaboration between healthcare providers regarding your care.

I, ______________________________ , hereby authorize Jennifer Reed NP, LLC to:

_______(initial) disclose information to

_______(initial) obtain information from

_______(initial) exchange information with

Name of Organization/Medical Provider:____

Address:__________________________________ City:_________________State:_____________Zip:_________

Phone:_______________________ Fax:_______________________

The following information:

_______(initial) Summary of treatment to include dates of contact, diagnosis, prognosis, treatment plans, intake summary, medications, laboratory results, genetic testing results, substance abuse treatment, and hospital records including discharge summaries.

The purpose of this request:

- Assist the person or organization to which the disclosure is being made in their provision of services
- Obtain information important in evaluation and treatment of the client and to provide information to the person(s) or organization to which disclosure is being made.

This consent to disclose may be revoked by me at any time upon my written request except to the extent action has been taken in reliance theron. This consent (unless expressly revoked earlier) will expire one year after the close of the case.

I acknowledge that I am aware that certain information I am consenting to release is confidential and protected by Federal and State Law. I acknowledge upon signing this consent that I am waiving my rights under these laws and that I am aware of the specific protections I am afforded or I am waiving my right to being informed of the specific provision of these laws. Statute – 42 CFR-Part2. K.S.S 65-5601 to 65-5605, inclusive.

It is expressly understood that photocopies/fax of this authorization shall be as valid as the original.

By my initials below,

I authorize exchange of information with my/my child's Primary Care Physician, Therapist, or other healthcare provider. I place no limits on dates, history of illness, diagnostic and therapeutic information, including treatment for alcohol and/or drug abuse.

Please list providers/individuals that you would like permission to collaborate or release information regarding your care:

Physician/Therapist name:____

Phone:_____________________Fax:_____________________

Physician/Therapist name:____

Phone:_____________________Fax:_____________________

Physician/Therapist name:____

Phone:_____________________Fax:_____________________

_______(initial) I hereby authorize the offices of Jennifer Reed to disclose my medical records, genetic results, and labs to the above parties. In the event I want to change the name of a physician or family member that has permissible disclosure, it is my responsibility to contact the office of Jennifer Reed, and or submit a new form. I have completed in full the information above to the best of my knowledge and ability.

____

Client Signature Date

____

Parent/Guardian Signature (If Client is a minor) Date