"Making Individuals' Lives Better"

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, _____ fully authorize KC OMHC to release/receive information regarding my Healthcare to:

Name/Agency: _____ Relationship to Client: _____

Address: _____

City, State, Zip: _____Phone# _____ Fax # _____

For the following purposes:

☐ Psychological Evaluation
☐ Psychological History
☐ Treatment Planning
☐ Diagnostic Testing
☐ Medical Test Results
☐ Medical Advance Directive
☐ Living will, durable power of attorney
☐ Vocational/Educational Information
☐ Necessary Rehabilitation Information
☐ Medication Information
☐ Financial, Entitlements/Benefits Information
☐ Job Placement Information
☐ Discharge/Follow-up Care
☐ Other/ Any Relevant Information

The information will be communicated via:

☐ Telephone ☐ Fax ☐ Email

Correspondence and is authorized to be communicated both ways:

☐ Yes ☐ No

The requested information will be used to help:

☐ formulate OMHC goals ☐ Coordinate treatment across my healthcare team.

I know that this authorization is voluntary, and will not affect my healthcare and payment if I refuse to sign it.

I understand that I may review the requested information, request and keep upon receipt, a copy of this authorization after I sign it.

I understand that the information provided by this request will be held in the strictest of confidence and is to be used only by the professionals on my healthcare team.

This authorization can be cancelled by me at any time, unless a process has already started and its completion depends on this authorization.

Signature: _____ Date:_____

Last Four:_____ Date of Birth: _____

Witness: _____ Date: _____

5801 Allentown Road Suite 310 Camp Springs, MD 20746 *www.kirstincare.com*
Office: 240-392-2876 Fax: 240-838-3015