Kansas City Center for Anxiety Treatment, P.A.
10555 Marty St., Ste. 100, Overland Park, KS 66212
(913) 649-8820 | (913) 649-8823 (Fax) | www.kcanxiety.com

Authorization for Release of Protected Health Information (PHI)

Patient's Full Name: _____ Patient's Date of Birth: MM / DD / YYYY

I authorize the Kansas City Center for Anxiety Treatment, P.A. to have a *bilateral* exchange of the information contained in the above patient's clinical record with the following individual or organization:

Please print. Do not leave individual/organization name blank.

Individual and/or Organization Name: required _____

Mailing Address: _____ Telephone: _____

_____ Fax: _____

City, State ZIP: _____ Email: _____

For the purpose of: ☐ treatment planning and coordination of care

☐ other; please describe: _____

This authorization expires on _____. If blank and no prior notice of revocation is received this authorization automatically expires one year from the last clinical date of service or, for minors, upon age of majority in the State of Kansas.

I understand that information disclosed pursuant to this release may be redisclosed by the recipient, may no longer be protected by privacy rules, and that KCCAT has no control over such redisclosure(s). I may cancel this authorization at any time—except to the extent of any action(s) already taken—by sending a signed-and-dated written request to the attention of KCCAT's Office Administrator by mail at 10555 Marty St., Ste. 100, Overland Park, KS 66212.

This authorization applies only to the above-named individual or organization, and any other transfer or disclosure requires additional authorization.

_____ _____

Signature of Patient (or Patient's Legal Representative*) Date

_____ _____

Printed Name Relationship (*if applicable*)

*KCCAT may require additional documentation for legal guardianship or power of attorney.