Serenity
Psychological Services & Consulting

1010 Downing Ave Ste 60
Hays, KS 67601
Phone: (785) 621-4417
Fax: 1(866) 473-6903

AUTHORIZATION TO RELEASE INFORMATION

I, **(name of patient)** _____, **(DOB)** _____, (hereinafter "Patient") hereby authorize:

_____
_____
_____

to disclose information and records to **Serenity Psychological Services and Consulting LLC**, (hereinafter "Provider").

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at **1010 Downing Ave Ste 60, Hays, KS 67601** to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:

☐Treatment ☐Evaluation ☐Other:_____

Such disclosure shall be limited to the following specific types of information:

☐Entry/Admission/Intake
☐Evaluation Results
☐Medication notes
☐School Records or IEP
☐Written/Verbal Progress Notes/Reports
☐Record of Attendance
☐Discharge report
☐Psychiatric Evaluation
☐Medical History
☐Case Consultation/Coordination of care
☐Treatment Plan
☐Summary of Care
☐Other:_____

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. Records are protected by Federal Regulations (42 CFR, Part 2) and applicable Kansas law. Patient has had this release explained to them and has had an opportunity to ask questions.

This authorization shall remain valid until: _____

Patient's signature: _____ Date: _____

Signature of Guardian: _____ Date: _____

Printed Name of Person Authorized to Sign:_____

Witness signature: _____ Date: _____