Attachment & TRAUMA THERAPY
913.346.1516 | attachmentandtraumatherapy.com

FOX CHILD & FAMILY THERAPY
913.229.5691
foxchildtherapy.com

Missouri
222 W Gregory Blvd, Ste 120, Kansas City
9200 NE Barry Rd, Ste 110, Liberty
2900 NE 60th St, Ste 206, Gladstone

Kansas
7223 W 95th St, Ste 220 & 300, Overland Park
25255 W. 102nd Terrace, Suite 200, Olathe

Release of Information Consent

Client First Name: _____ Client Last Name: _____ Client Date of Birth: _____

I authorize my therapist: _____ Check all that apply: ☐ To Send ☐ To Receive

The following information:

☐ Medical history and evaluation(s) ☐ Mental health evaluations
☐ Developmental and/or social history ☐ Educational records
☐ Progress notes ☐ Diagnostic assessment
☐ Treatment plan ☐ Billing and financial information ☐ Scheduling information ☐ Other

Dates of records to be released:

☐ All records
☐ Records from (start date): _____ to (end date): _____
☐ Specific date(s) of service: _____

To be provided to or released from: _____ Phone: _____
Address: _____ Fax (Required): _____

The above information will be used for the following purposes:

☐ Planning appropriate treatment or program ☐ Continuing appropriate treatment or program
☐ Determining eligibility for benefits or program ☐ Case review ☐ Updating files ☐ Personal use
☐ Other

I have been informed what information will be given, its purpose, and who will receive the information.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice.

****Unless otherwise revoked, this authorization will expire on the following date: _____**

- **If I fail to specify an expiration date, this authorization will expire one year from the date signed.**

I understand that his information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws.

I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that I have a right to receive a copy of this authorization.

I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach/provide a copy of that documentation to this authorization to receive this protected health information.

Name: _____ Relationship to Client (if client is a minor): _____

_____ _____

Client Signature Date