SUSAN CLAVETTE INTEGRATIVE PSYCHIATRIC NP, LLC
EMPOWER MENTAL HEALTH
7171 W 95th St, Suite 210 Overland Park, KS 66212
913-210-6005; FAX 913-210-6008
office@empowerkc.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: __X____ DOB: _X_________________________
Address: __X____ Phone: _X___________________

I authorize the release of the following protected health information:

Name of Physician/family/Address __X____
____ Office Notes ___Lab Reports ____ Other: ________________: _____ Paper Copy __X___ Electronic Copy

The purpose for this request to release medical information is:
___X__ Medical Care/Treatment _____ Insurance __X__ Other (specify__Collaboration of treatment__

Send my medical information to: Name: ________Susan Clavette, APRN, BC____________________________
Complete Address: __7171 W 95th St, Suite 210 Overland Park, KS 66212______________________________
____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. This office shall not be held liable for any consequences resulting from re-disclosure.
- A copy of this signed form will be provided to me upon my request.
- This office may charge an administrative fee to cover the cost of labor, copying, and/or postage. This office will inform me of any charges and arrange for payment.
- This authorization expires on ____/____/______ (if date not completed/5 years after signed).

__X____ ____________________ _________________
patient/representative signature date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

____ _____________________ ________________
Printed name of patient.representative date