The Attention and Learning Clinic

1900 Amidon - Suite 200 - Wichita, KS 67203
Phone 316-558-8085 - Fax 316-558-8086

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

***Patient Name*: _____*DOB*:_____**

I authorize The Attention and Learning Clinic to: (Initial One)
X ____Exchange information with: Dr:_____Ph #_____
_____Disclose information to: USD#_____ School_____
_____Obtain information from: Ph #_____Fx #_____
Other:_____

This information may be disclosed for the following purposes: (Initial One or More)
X_____ To coordinate treatment
_____ At the request of the patient or representative
_____ Other_____

The following information may be disclosed: (Initial each type of information to disclose)

X_____ Outpatient records including admission summary, psychological consultation and testing reports, treatment plan, and progress notes – including verbal and written communication
_____Admission summary only
_____Psychological consultation (testing) report only
_____Progress notes only
_____Verbal communication only
X ____Other: School Performance, Behavior/Medical Information

This authorization will expire _____(or one year from date signed if not specified)

This request is entirely voluntary on my part and I can revoke the authorization at any time, except to the extent that action based on this request has already been taken, by putting the revocation in writing and delivering it to The Attention and Learning Clinic. I understand the nature of the records I have requested to be released. I also understand that the information disclosed under this authorization might be re-disclosed by the recipient.

_____ _____
Printed name of Patient *Printed Name of Representative*

_____ _____
Patient's Signature *Representative's Signature*

X_____ _____
Date *Representative's relationship to patient*

_____ _____
Attention and Learning Clinic Staff/ Date Date

Patient Name: _____ ID: _____