LEWIS PSYCHOLOGICAL SERVICES

RELEASE FOR EXCHANGE OF INFORMATION

This authorizes the following person or organization to release the following information to the Lewis Psychological Services and the Lewis Psychological Services to release to the following person or organization the following information:

____

(Name of person or organization)

The information to be released by Lewis Psychological Services:

_______ History
_______ Diagnosis
_______ Summary of Treatment
_______ Medications
_______ Lab Work
_______ Psychological Testing
_______ Psychiatric Evaluation
_______ Alcohol/Drug Evaluation
_______ Substance Abuse TX
HIV/AIDS Status (other
_______ communicable disease)
_______ Case Management Treatment Plan
_______ communication

The information to be released to the Lewis Psychological Services:

_______ History
_______ Diagnosis
_______ Summary of Treatment
_______ Medications
_______ Lab Work
_______ Psychological Testing
_______ Psychiatric Evaluation
_______ Alcohol/Drug Evaluation
_______ Substance Abuse TX
HIV/AIDS Status (other
_______ communicable disease)
_______ Other (Specify)
communication

and is to be released or obtained for the purpose of ______________________________________

Except for purposes of collection of revenues for professional services rendered, this consent to release is valid for **one (1) year** or until otherwise specified and thereafter is invalid.

____

Specify date, event or condition that permit will expire.

You are advised that at any time between the time of signing and the expiration date listed above, you have the right to revoke this consent, by making this request verbally and/or to write your request to AMHC.

I understand that said information disclosed may contain psychiatric (K.S.A. 59-2946), substance abuse (42 C.F.R. Part 2) and/or HIV/AIDS (or other communicable disease K.S.A. 65-6001, -6004, -6008, -6009, -6016 and 60-427) information. I understand that my records are protected under the Federal and State confidentiality regulations and cannot be released without my written consent unless otherwise provided for in said regulations.

____

Patient's Name (Maiden or Former Name) | Date of Birth

____

Address

____

Witness | Date | Client/Patient Signature (Age 18 years and over | Date

____

Position | Signature of Responsible Party, Parent, Guardian if under age 18 | Date

____

Relationship to Client

____

Print Name of Parent or Responsible Party if under age 18

____

Patient's or Authorized Person's Signature for Authorization of Payment

(I authorized the payment of medical benefits to the physician or supplier for the services described on the attached claim.)

Please send information to the following address:

Lewis Psychological Services
P. O. Box 632
Ulysses, Kansas 67880