484 Tollage Creek Road
Pikeville, KY
Phone: 606-888-7337
Fax: 606-432-1616

Compassion Pediatrics Behavioral Health Services
AUTHORIZATION TO RELEASE MENTAL HEALTH INFORMATION

Client Name: ______________________________ DOB: ____________________________

Authorize Compassion Pediatrics and its representatives to exchange information with:

Name/Organization: ________________________________ Phone Number: __________________

Address: ____ Fax Number: _____________________

Specific nature of information to be released:

___ all of the following
___ attendance/scheduling
___ information related to payment
___ presenting complaints/issues
___ screening and/or assessment results
___ treatment plan and goals
___ summary of visits
___ treatment/progress
___ medication management progress notes
___ other:

The information above is being released for the purpose of:

___ facilitating consultation and/or collaboration
___ facilitating scheduling/transportation
___ facilitating family involvement in treatment
___ facilitating communication with school officials
___ facilitating continuity of treatment
___ facilitating payment
___ other:

I understand that:

1. This consent will automatically expire one year from signing unless a different date of expiration is specified here: ____
2. I have the right to copy and inspect the information being disclosed.
3. I have the right to revoke this authorization, in writing, at any time by sending such written notification to my provider's office.
4. Parents/guardians may submit a request to receive a copy of their child's medical record (will be made available in 24-48 hours) however, per the HIPAA Privacy Rule (45 C.F.R.§ 164.501) therapy notes are separate from the medical record.

X____ __________________________________
Signature of patient (age 16 years or older) Date:

X____ __________________________________
Signature of Legal Representative for patient under 18 Date:

X____ __________________________________
Signature of Staff Date: