Geenens Psychiatry

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Authorization for Release of Medical Information

Patient Last Name: _____ **First Name**:_____ **MI**:____ **DOB**:____/____/____
Address:_____ **City**:_____ **State**:_____ **Zip Code**:_____
Email Address: (Optional)_____ **Phone Number**:_____

I authorize the release of my medical/psychiatric records from:

Name of Facility:_____ **Phone Number:**_____
Address:_____ **City**:_____ **State**:_____ **Zip Code**:_____
Fax Number:_____ **Email Address:**_____

I authorize the following individual(s) access to information regarding my time as a patient of Geenens Psychiatry:

Name:_____ **Relationship:**_____ **Phone Number:**_____
Name:_____ **Relationship:**_____ **Phone Number:**_____
Name:_____ **Relationship:**_____ **Phone Number:**_____
Name:_____ **Relationship:**_____ **Phone Number:**_____
Name:_____ **Relationship:**_____ **Phone Number:**_____

By signing this authorization form:

I authorize that Geenens Psychiatry may release confidential information about me, by releasing a copy of my medical records, or by a summary/narrative of my psychiatric information to the facilities/physicians/individuals listed above.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present it to the office staff in person or via email. Revocation will not apply to information that has already been released in response to this authorization. I certify that a photocopy of this authorization is as valid as the original.

I acknowledge and certify that I am indeed the individual signing this authorization. Falsifying a signature is considered fraud and is punishable by federal law.

Patient/Authorized Representative Signature:_____ Date:_____
Printed Name of Patient/Authorized Representative:_____
Relationship to Patient (If applicable):_____

Send completed form to: Geenens Psychiatry, 4901 W. 136th St, Leawood, KS 66224
You may also email the completed form to: arthurc@geenenspsychiatry.org