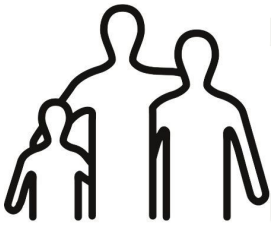
MidAmerica Family Treatment Center



4031 Central Street Kansas City, Missouri 64111 913-626-1018

RELEASE OF INFORMATION AUTHORIZATION

FOR THE RELEASE OF PROTECTED MENTAL HEALTH INFORMAITON

By signing this form, confidential mental health information can be released to and or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and you may make changes at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of the revocation.

1. I authorize MidAmerica Family Treatment Center to ☐Release ☐Receive psychological/psychiatric/mental health information to/from SECOND PARTY as directed below concerning:_____(name of child this concerns)
2. SECOND PARTY:
   Name:_____
   Address:_____
   City:_____State: _____Zip_____
   Fax Number:_____Phone:_____
3. DESCRIPTION OF MENTAL HEALTH INFORMATION TO BE DISCLOSED:
   ☐Alcohol and Substance Use ☐Discharge/Services Summary
   ☐ Consultation Reports ☐Progress Notes
   ☐ Medications ☐Treatment Plan
4. PURPOSE OF DISCLOSURE:
   ☐Consultation ☐ Continuation of Care ☐Insurance
   ☐ Legal Proceedings that affect the child/children in question
   ☐Parent/Partner Consultation ☐Other
5. Note any exclusions or limitations here: _____

I understand that treatment, payment, enrollment in a health plan or eligibility for benefits is NOT dependent on my signing this authorization.

By Signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my authorization to MidAmerica Family Treatment Center to disclose my child's records and that I may revoke this authorization at any time in the future. This consent will expire one year from the following date signed unless revoked by you in writing or upon the event or condition as lised on the following date:_____

Parent Signiture:_____Date_____

Witnessed by: _____ Date_____