AUTHORIZATION TO OBTAIN OR RELEASE HEALTH CARE INFORMATION

Client Name:_____ SS#:_____
Date of Birth:_____ Parent/Guardian:_____

I authorize the following individual or agency to share written and oral information (two-way or reciprocal release) about my needs and the services I received.

Name of individual/agency to release and receive information:_____
Address:_____ City/State/Zip_____
Phone:_____ FAX:_____ Email:_____

With the following individual:
Name of provider: Richard L. Benson, Ph.D.
Address: 5750 West 95th Street, Suite 320 Overland Park, KS 66207
Phone: (913) 596-8808 FAX: (913) 242-7358 Email: drb@bensonpsyc.com

The information released or shared may include:
_____Narrative summary ___Psychological evaluation _____ Therapy Progress Notes
_____ Verbal Exchange of Information _____ Other (specify) _____

This information is being used ONLY for (state purpose):_____

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I can revoke my authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire in six months after the date it is signed. I understand that authorizing this disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my provider at (913) 596-8808. I have read this form, or it has been read and explained to me, and I understand its content.

Authorizing Signature:_____ Date:_____ Exp. Date:_____
Relationship to Client: Self Parent/Guardian Other (specify)_____
Witness Signature:_____

A photocopy of this signed authorization shall have the same force and effect as this original.