

**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: 7111 West 151<sup>st</sup> Street, Suite 286 Overland Park, KS 66223  
Phone: (913) 596-8808 FAX: (913) 897-7487 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.