Amy M. Jacobsen, Ph.D. LLC

Authorization to Disclose Protected Health Information

_____ _____
Patient's Name Patient's Date of Birth

_____ _____
Parent or Guardian's Name (if applicable) Phone

I, the undersigned, hereby authorize **Dr. Amy Jacobsen** to have a bilateral exchange of Protected Health Information (PHI) from the individual's clinical record with:

_____
Name of Individual, Provider, Agency, or School

_____
Address

_____ _____
Phone Number FAX

Purpose(s) of the use or disclosure:

□ treatment planning and coordination of care □ personal

□ other (please describe):_____

By signing below, I understand the following:

- This authorization is effective until _____ or for one year from the date on which it was signed (if no date specified).
- That I may cancel this authorization at any time, except to the extent of action(s) already taken, by sending a signed-and-dated written request to the attention of Amy M. Jacobsen, Ph.D. LLC, 8400 W. 110th Street, Ste. 610, Overland Park, KS 66210.
- That any information released prior to revocation and which was because of this authorization will not constitute breach of confidentiality.
- That there may be a fee for this service if photocopying, faxing or mailing a large amount is involved, and if so, I agree to pay the fee to Amy M. Jacobsen, Ph.D., LLC prior to receipt of the requested information.
- That information may be sent via secure fax or email, and if information is inadvertently received by an unauthorized recipient, through no fault of the sender, I waive claim against the sender.
- I understand that if my Protected Health Information (PHI) is disclosed to someone who is not required to comply with privacy protections under HIPAA, then such information may be re-disclosed and no longer protected. I relieve Amy M. Jacobsen, Ph.D., LLC of all responsibility for unauthorized disclosure or breach of confidentiality that may result due to this disclosed PHI being in my custody and control or the other third party described above.
- That additional consent much be obtained for any other transfer or disclosure of this information.
- That certain patient information may be protected by Federal and/or State of Kansas laws, which may prohibit the release of such patient information. I understand that Amy M. Jacobsen, Ph.D., LLC is compelled to comply with such laws.
- That I have a right not to authorize the use and/or disclosure of my PHI. In such a case, I would choose not to sign this authorization document.

I certify that I agree to uses and disclosures listed above. I can receive a signed copy of this authorization at my request.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Printed Name Relationship to Patient

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