Mickey Simpson, L.S.C.S.W./L.C.S.W._____

8010 State Line Road Ste 101
Prairie Village, KS 66208
816.305.8830

RELEASE OF INFORMATION

Patient Name _____ Date of Birth_____

I authorize Mickey Simpson, L.S.C.S.W./L.C.S.W.

____ to disclose to _____to receive from

Name_____

Address_____

Phone_____

The following information from my records either in verbal or written form:

____ Medical Treatment
____ Medical History
____ Summary of Treatment
____ Legal Proceedings
____ Other (specify)_____
____ Social History
____ Psychological Treatment
____ Discharge Summary
____ Treatment Recommendations

The purpose of this disclosure is:

____ Continuity of Services
____ Fulfill Requirements of Referring Agency
____ Other (specify)_____
____ Medication Consult
____ Legal Proceedings

This consent expires on _____
(Specify date, event, or condition on which it will expire)

I understand that I may revoke this authorization at any time through dated, written communication. I also understand that I may not retroactively revoke my permission. I understand that I have the right to withhold my consent.

_____ _____
Date of Authorization Signature of Client

_____ _____
Signature of Parent, Legal Representative, or Guardian Relationship