RELEASE OF INFORMATION AUTHORIZATION FORM

I authorize Dr. Casey Bodenhausen LLC,
____to release ____to obtain from ____to exchange information with the following individual and their staff or agency as specified below (specify the information to be disclosed). Communication will be face-to-face, using phone, fax, mail, hand delivery and/or internet. Privacy statements will accompany all written communication using fax or internet. This information should only be released to:

_____
Name

_____
Address

_____
City, State and Zip Code

_____
Telephone Number Fax Number

I am requesting that my mental health professional release this information for the following reasons: Continuity of patient care. **This authorization shall remain in effect for one year from today's date or until the date specified: Until termination of treatment or notified in writing**. I understand that my treatment generally is not contingent upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Note: You have the right to revoke this authorization, in writing, at any time by sending such written notification to your therapist at 8700 Indian Creek Pkwy, Building 3, Suite 270, Overland Park, KS. 66210. However, you revocation will not be effective to the extent that action has already been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____ _____
Signature of Patient Date

_____ _____
Print Name Date of Birth