Larned State Hospital
Larned, Kansas

Rev 9/13

AUTHORIZATION FOR RELEASE OF INFORMATION
CPR-127

I, _____ , _____
(Patient's name) (Date of birth)

hereby authorize Larned State Hospital
(Name of agency, program, or individual and title)

to disclose to _____
(Name of agency, program, or individual and title)

The following information from my records (specify extent or nature of information to be disclosed):
Any and all medical records, including, but not limited to, treatment, evaluations, intake, discharge, etc.

I am also making the following additional qualifications: IF the information specified above contains information related to treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions or HIV test results or diagnosis, I AM including that this type of information be released in association with this authorization.

The purpose of this disclosure is: My legal defense.

Medical records are protected by Federal Regulations, Kansas Statutes and/or Administrative Regulations and any further disclosure is prohibited without the undersigned consent. If applicable, disclosure made pursuant to this authorization shall be accompanied by a written statement regarding redisclosure as provided for by Federal Regulation 42 C.F.R. Part 2.

This authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereon.

Specify the date, event, or condition upon which the consent expires: _____

(If left blank, expiration date is 60 days after the date entered below)

I understand that my treatment or payment of my bills may not be conditioned on my decision to sign this authorization.

Date | Time | Patient's Signature

Witness | Parent or Legal Guardian's Signature

Original: Master File
Copy: Patient