

NORTHLAND PSYCHIATRIC SPECIALISTS, LLC

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AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Also known as: _____ Phone #: _____

Social Security #: _____

I authorize Northland Psychiatric Specialists, LLC to release confidential information regarding my treatment to: (family members or other persons)

Name: _____ Relationship: _____

I also authorize Northland P Psychiatric Specialists, LLC to release confidential information regarding my treatment to: (Primary Care Physician and/or therapist/counselor)

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

_____ **I DO NOT AUTHORIZE** Northland Psychiatric Specialist to release confidential health information to anyone other than myself. I do understand that this information may be needed by other healthcare providers to receive comprehensive and quality healthcare.

This information includes but is not limited to appointment information, billing information and medication information.

I understand that by signing this form I am allowing Northland Psychiatric Specialists, L.L.C. to receive and review confidential health information. I understand that this consent is voluntary and is subject to revocation at any time, except after the information has already been received and may only be revoked by signature.

Patient Signature: _____ Date: _____

NOTICE OF REVOCATION.....THIS REVOCATION CANCELS MY AUTHORIZATION GIVEN ABOVE.

Print Name: _____ Signature: _____

NPS Staff: _____ Date: _____