Amy Buckman, LCPC, LPC

7381 W 133rd St, Overland Park, KS 66209
Phone: (913) 484-8294 | Fax: (913) 270-0064

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Information:

Name _____ Address _____

Date of Birth _____ _____

Parent/Guardian _____ Phone _____

Authorization for Release: I hereby authorize the exchange of confidential information (see "Specific Authorization" below) between the following parties:

Amy Buckman, LPC
7381 W 133rd St
Overland Park, KS 66209
Phone: (913) 484-8294
Fax: (913) 270-0064

AND

_____
(Name of person or organization)

_____
(Street address)

_____
(City) (State) (ZIP)

_____
(Phone) (Fax)

Specific Authorization: I specifically authorize the release and/or exchange of ALL confidential information relating to the above-named client, including, but not limited to, the following categories protect by state and federal law: HIV/ AIDS-related information, if such information is contained in the records. This authorization includes reports, correspondence, test results and any other information in the records, whether generated by the authorized provider or another entity.

Redisclosure: This release does not authorize redisclosure of confidential information beyond the limits of this consent. The Recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization. The following written statement should accompany certain disclosures:

> **"This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of confidential or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."**

I specifically understand and agree that the REDISCLOSURE requirements set out above will apply to these records.

Validity: I understand this authorization will automatically expire one (1) year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorize the release of information as indicated above.

_____ _____
(Signature of Client or Guardian) Date