Stacey Laird, MD, LLC

4121 West 83rd Street, Suite 204, Prairie Village, KS 66208 | (913)283-7095 | FAX: 913-242-7060

Patient Name: _____ **Patient DOB**: _____

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

The undersigned patient or responsible party (parent, legal guardian, or conservator) hereby consents to, and authorizes, Dr. Stacey Laird, MD to have bilateral exchange of information contained in the medical records of the above listed patient with:

Name of Physician: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

This information is requested for the purpose of:

_____ continuing care and/or treatment

_____ other:

This information will be limited to:

_____ Psychiatric/medical/alcohol/drug abuse evaluation

_____ Psychiatric/medical/alcohol/drug abuse discharge summary

_____ Progress notes _____ Psychological testing _____ Psychotherapy notes

_____ Educational testing _____ Lab studies _____ School performance

_____ Medical tests/studies _____ Other:

He/she understands that he/she has the right to cancel this Consent at any time by sending a signed and dated written request to Stacey Laird, MD, LLC indicating the desire to cancel. He/she understands that once the information has been released to the above listed entity the recipient might re-disclose it, Dr. Stacey Laird has no control over it, and privacy laws may no longer protect it. He/she understands that an additional consent must be obtained for information to be exchanged or disclosed to any other entity. He/she understands that he/she is entitled to a copy of this Consent, upon request.

_____ _____
Signature of Patient Date signed

_____ _____
Signature of Parent, Legal Guardian or Conservator Date signed

_____ _____
Printed Name of Parent, Legal Guardian or Conservator Relationship to Patient