Healing MINDS
It's what we do

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date of Birth**_____ **Phone** _____

I Authorize:	**To Release To:**
Name of Person or Entity: _____	Name of Person or Entity: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone #: _____ Fax: _____	Phone #: _____ Fax: _____

Information that may be released: (Boxes must be checked to authorized release)

☐ Psychotherapy assessment ☐ Psychotherapy treatment plans ☐ Psychotherapy notes

☐ Billing records ☐ All medical records ☐ Other (please specify): _____

PURPOSE FOR WHICH INFORMATION IS TO BE USED: (copy fee $.60 per page)

☐ Continuing Care ☐ School Disability benefits ☐ Scheduling

☐ Legal ☐ Personal Employment conditions

☐ Other (Please Specify): _____

If for legal purposes, give specific reason: (must be completed) _____

AUTHORIZATION:

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoked this authorization at any time, except to the extent that action has already been taken to comply with it. Revocation must be in writing. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. Refer to the Notice for Privacy Practices regarding authorized disclosures. A legible copy of the Authorization or my signature thereon may be used with the same effectiveness as an original.

OTHER CONDITIONS:

This information has been disclosed to you from records whose confidentiality may be protected by Federal Law: "Federal regulation (42 CFR, Part 2) prohibits 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 such regulations. A general authorization for the release of medical 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." [RM 203, 7.2] Rev. 4-12-04_

This consent expires one year from the date below unless otherwise specified: (not to exceed one year)

Patient age 11 and younger require parent/guardian signature only; Based of services provided, signature of both patient and parent/guardian may be required for patients age 12-17; patients age 18 and older must sign exclusively unless there is a legal guardian.

***DISCLAIMER**: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.*

_____ _____ _____ _____

Signature of patient (sign or print): Date **Signature of Parent/Guardian, if applicable (sign or print):** Date

Revocation: I hereby revoke the above authorization: **Signature (sign or print):** _____ Date _____