The Mind Center

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www.TheMindCenter.me

Release of Protected Health Information

This form, once completed and signed, authorizes the release of your protected health information (PHI) to the person(s) you designate. You have a right to receive a copy of this completed authorization form upon your request.

By signing below, I PRINT NAME HERE: _____

DATE OF BIRTH:_____

hereby authorize The Mind Center to release and/or receive the following information:

____ Copies of psychological evaluation
____ Copies of psychotherapy progress notes and/or interim summary reports of therapy
____ Medical records from other providers: _____
____ Other: _____

This information should only be released to (name, address, and phone/fax):

_____
_____
_____
_____

I am requesting to release this information for the following reasons:

_____

If I have been diagnosed or treated for ANY of the following, I understand my specific consent to disclose related information is necessary. I understand I may cross out any conditions that do not apply or that I do not wish to be disclosed. I do understand that in most cases, written psychological records will include sensitive information about psychiatric illness as well as any past or current substance use.

I (**DO/** ~~DO NOT~~) authorize disclosure of information related to treatment or diagnosis of:

- drug abuse or
- alcohol abuse or
- psychiatric illness
- HIV/AIDS

I understand I can revoke this authorization and release of information at any time by sending written notification to the office address above. I do understand that revoking this authorization will not be effective to the extent that _____ may have already taken action in reliance on my authorization. I understand that I may refuse authorization to disclose all or some healthcare information, but that refusal or revocation may result in improper diagnosis or treatment, denial of insurance coverage, or other adverse consequences. I also understand that information disclosed by this release of information may become subject to re-distribution or re-disclosure by a recipient of the information and therefore may no longer protected by the HIPAA Privacy Rule (e.g., if accidentally disclosed to someone who is not a healthcare provider bound by privacy rules).

Once signed, this release of information will remain in effect for ONE YEAR, or until: _____ .

X_____ X_____ X_____

Signature **Printed Name** **Date**

_____

If the authorization is signed by a personal representative of the patient (e.g., legal guardian, parent, or power-of-attorney), a description of such representative's authority to act for the patient must be provided.