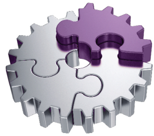

MasterMind Psychology, P.S.

Consent for Release of Confidential Information

In regards to: ______________________________________ ____________________
Name of client Date of birth

The undersigned authorizes:
MasterMind Psychology, P.S.
101 W Cataldo, Suite 210, Spokane WA 99201
(Ph) 509-292-6629 (Fax) 509-292-6629

_____ Information to be released to:
_____ Information to obtained from:

____
Institution/Facility/Person(s)

____
Address

______________________________ ______________________________________
Phone Fax

Description of information to be disclosed:

__ Complete Copy	__ Psychological Testing	__ Treatment Plans
__ Progress Notes	__ Educational Testing	__ School Records
__ Consultation Notes	__ Psychiatric Testing	__ Pathology Report

__ Other (Specify): ____

Health information to be disclosed/used for the following purposes:
______ Continuing care ______ Insurance purposes ______ Legal purposes
______ Other: ____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that this authorization may include disclosure of information relating to mental health, psychiatric treatment, drug/alcohol abuse, and/or HIV/AIDS information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization. There may be a charge for these copies.

This authorization will automatically expire six months from the date signed or when the 3rd party payor claim is settled. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. To revoke this authorization, I must submit my request in writing to MasterMind Psychology, P.S.

Client/Parent/Guardian/Legal Representative Signature ___________________________

Print Name ____________________________________ Date _____________________