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Records Release Authorization

Date of Records Request: ___________________

Patient: ___________________________________ Date of Birth: _______________

Address: ____

Phone: ____

Reason for Request: ____

If transferring, why? ____

I authorize Daring Minds Therapy, LLC to send **and / or** receive information from:

Agency______________________________ Primary Contact ___________________________________

Phone ______________________________ Secure Email _______________________________________

Address _______________________________________ Fax _____________________________________

Records authorized to be released shall be limited to the following information: (please initial each box as appropriate)

☐ Evaluation Report ☐ Medical History ☐ Diagnosis

☐ Social History ☐ Treatment Plan ☐ Progress Notes

☐ Discharge Summary ☐ Psychological Testing ☐ Legal Record

☐ Written and Verbal Communication ☐ Other (please specify): _____________________

I understand that information may include drug and / or alcohol use or abuse, or psychological care or psychiatric care and that this information will not be release to any other agency, individual, or organization for any other purpose without written consent except as required by Federal or State Law, including 42 CFR Part 2 and HIPAA. This release will expire one year from date of authorization.

I understand that I may revoke this authorization at any time by sending written notice to Daring Minds Therapy, LLC. If I do so, I know that it cannot apply to any information that had been released before receipt of my written notice. I also agree that a photocopy of this release is valid as the original.

___________________________________ ___________________________________

Signature of Patient or Representative **Witness**

___________________________________ ___________________________________

Date **Date**

____

Relationship of Representative to Patient