Resilient Hearts Therapy

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Client name: _____ Date of birth: _____

I, _____, authorize ***Resilient Hearts Therapy*** to: ❒ Release ❒ Receive

the following information (check all that apply):

- ❒ Medical history including tests/evaluation(s)
- ❒ Mental health evaluations and results/diagnosis
- ❒ Legal status
- ❒ Educational records, assessments, and/or reports
- ❒ Summary of psychological/psychiatric history
- ❒ Other: _____

To / From: _____ Phone: _____

Your relationship to client: ❒ Self ❒ Parent/ guardian ❒ Personal Representative ❒ Other: _____

The above information will be used for the following purposes (check all that apply):

- ❒ Planning appropriate treatment or program
- ❒ Continuing appropriate treatment or program
- ❒ Determining eligibility for benefits or program
- ❒ Case review
- ❒ Updating files
- ❒ Other: _____

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

❒ By checking this, you are eSigning this form.

_____	_____	_____
Client/Guardian Name Printed	Client/Guardian Signature	Date