Serendipity Therapy Services
850 Tower Dr. Ste 106
Odessa, TX, 79761
(432) 530-6452

Authorization to Release Mental and Medical Health Records

Client Name:	
Address:	
City:	State:
Zip:	Phone #:

I, _____, parent or guardian of _____, authorize the disclosure of information related to my child's mental or physical health from and to the named providers below. I understand that I may be required to sign additional disclosure paperwork with my child's other providers to ensure appropriate continuity of care.

Organizations/Entities Authorized to Disclose Private Health Information	
Serendipity Therapy Services	Name of Entity or Individual:
855 Central Dr. #8	Address:
Odessa, TX, 79761	City/State/Zip:
(432) 530-6452	Phone:

The protected health information to be disclosed includes the following: (check all that apply)

___ Assessment Information
___ Diagnosis
___ Treatment Planning Notes
___ Progress & Treatment Notes
___ Communicable Disease Information
___ Medication
___ Psychiatric Evaluation
___ Results of Psychological Testing
___ Recommendations
___ Reasons for Termination
___ Appointment Information
___Other: Please explain
_____

For the purpose of continuity of care, education, legal, insurance, billing, and collaboration.

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I understand that this release is valid for one year or until I withdraw my consent in writing, whichever occurs first. Withdrawal of consent for the release of mental health and medical records does not destroy or remove records or information already obtained.

I acknowledge that this authorization is voluntary and that payment or eligibility for benefits for my health care will not be affected if I do not sign this form. I also understand that the information disclosed because of this authorization may no longer be protected by privacy laws and may be disclosed by the company or individual receiving the information.

_____

Parent/Guardian Printed Name

_____ _____

Signature of Parent/Guardian Date