**Release of Information for Mental Health Treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, whose Date of Birth is \_\_\_\_\_\_,

authorize Positive Mind Therapy, LLC (PMT) to disclose to and/or obtain from:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the following information:

**Description of Information to be Disclosed**

(Initial items to be disclosed) \_\_\_\_\_All Items below

\_\_\_\_\_ Assessment \_\_\_\_\_ Diagnosis

\_\_\_\_\_ Psychosocial Evaluation \_\_\_\_\_ Psychological Evaluation

\_\_\_\_\_ Psychiatric Evaluation \_\_\_\_\_ Treatment Plan or Summary

\_\_\_\_\_ Current Treatment Update and Progress \_\_\_\_\_ Medication Management Information

\_\_\_\_\_ Presence/Participation in Treatment \_\_\_\_\_\_Nursing/Medical Information

\_\_\_\_\_ Educational Information \_\_\_\_\_ Demographic Information

\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose**

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is for marketing, sale of information or research, please specify:

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**Revocation**

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to PMT at . I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

**Expiration**

Unless sooner revoked, this authorization expires in 1 year from signed date or as otherwise indicated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Form of Disclosure**

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

**Redisclosure**

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

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Signature of Client Date

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Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

\_\_\_\_\_Check here if patient/client refuses to sign authorization

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of PMT Social Worker Date

Revision of NATIONAL ASSOCIATION OF SOCIAL WORKERS © Popovits & Robinson, P.C. 2013