Mindful Being Counseling, LLC

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Authorization for Release of Protected Health Information

I, _____, DOB: _____, authorize Mindful Being Counseling, LLC to:
☐ Disclose to ☐ Obtain from ☐ Exchange with

Name (Person/Agency): _____

Address: _____

Phone: _____ Fax: _____

Regarding: ☐ Myself OR ☐ Child-Name: _____ DOB: _____
The following information:
☐ All health information
☐ Diagnosis and/or Diagnostic Impressions
☐ Diagnostic Evaluations
☐ Discharge/Treatment Information
☐ Medical Opinion/Medical Exception
☐ Appointment related information
☐ School Records/Functioning
☐ Criminal Records/Information
☐ Provider/Hospital Records/Medical History
☐ Other: _____
the following must be indicated separately EVEN if "ALL" is checked above
☐ Psychotherapy Notes
☐ Chemical Health Records

I understand that all information about me is private. It cannot be shared with anyone without my permission unless the law says it can. I understand that I may refuse to give my permission to share this information. If I refuse, I may not receive the services I am requesting. I understand that I may revoke this consent at any time by express written notice to Mindful Being Counseling, LLC to the extent that action has been taken in reliance on it or information has been received as a result of it. I understand that this information will be given only to people who need it to do their jobs. The information will be used only for the reason stated above.

This form will expire automatically in:
☐ 1 Month ☐ 6 Months ☐ 12 Months ☐ Upon receipt/submission of requested information

Purpose for this disclosure:
☐ Coordination of Care ☐ Client Request ☐ Referral ☐ Discharge or Continuation of Care
☐ Legal ☐ Insurance ☐ Other: _____

_____
Printed Name

_____ _____
Signature Date

_____ _____
Signature *(Parent/Guardian/OTHER LEGAL REPRESENTATIVE)* Date

_____
Printed Name and Relationship (*if applicable)*