

**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 items below must be indicated separately EVEN if “ALL” is checked above\*\**

Psychotherapy Notes

Chemical Health Records

Purpose for this disclosure:

Coordination of Care  Client Request  Referral  Discharge or Continuation of Care

Legal  Insurance  Other: \_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form will expire automatically in 12 Months unless otherwise specified below:

1 Month  6 Months  Upon receipt/submission of requested information

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.

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

Printed Name

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

Signature Date

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

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

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

Printed Name and Relationship (*if applicable)*