Authorization for Release of Information

I authorize **Healing Minds Center** [*Jeanne Morris Foley, Rebecca Rainis, Kaymarie McIntosh,* _____] to discuss (verbally or in writing) anything that has been brought up during our psychotherapy or evaluation with any person/s or staff of clinic, office, agency, or institution/s named below and receive any relevant information from them.

Client name: _____ Client DOB: _____

I authorize **Healing Minds Center** to (check one or both):

☐ OBTAIN AUTHORIZED INFORMATION FROM

☐ RELEASE AUTHORIZED INFORMATION TO

Any person or party listed below:

Name	Relationship	Contact Information

The information to be released/obtained is as follows (check all that apply):

☐ Reports & Evaluations ☐ Screening Information

☐ Treatment Plan/s ☐ Coordination of Care

☐ Intake & History ☐ Counseling Notes

Any and all information deemed necessary for treatment and services

Other: _____

Information that may not be disclosed (please specify any restricted information, as needed):

I authorized the disclosure of the protected health information by:

☐ Fax ☐ Phone ☐ Oral ☐ Email ☐ Written

- I understand this information is required for the purpose of any necessary and ongoing needs inclusive of evaluations and recommendations for further treatment.
- I understand that my health care record contains information relating to diagnosis and treatment. I authorize the release of all such information listed above, except any items I have specified about. I further understand that I may request to review my records and refuse authorization to disclose all or some of the above health care information. I am not requesting to review the records in advance.
- I understand that treatment, payment, enrollment, or eligibility for benefits may not be contingent on this authorization.
- I understand the information disclosed, as permitted by this authorization may no longer be protected by **Healing Minds Center** after disclosure. I do understand that local, state, and federal laws do exist to protect the confidentiality of this information.
- I understand this consent is in effect for five years from the date of the last session, unless revoked in writing earlier or renewed.
- I understand this consent is also subject to all conditions outlined in the Official Practice Policies form.
- I authorize the periodic, ongoing disclosure of the above information. This authorization expires when services are discontinued. If authorization is granted following termination of services, the authorization will expire within 90 days after the date of authorization.
- I understand that I may revoke this consent at any time by written notice to the provider except where the provider has already acted upon an authorized request for the release of a record.
- I understand that I am entitled to a copy of this authorization. A photocopy of this authorization shall be considered as effective and valid as the original.

Name: _____ Date: _____

Signature: _____