Release of Information

I, ___________________________________, DOB: __________________, authorize Mending Mind Wellness, LLC, to:

________ Release to: and/or ________Obtain from:

Start Date:____________________ End Date:_____________________

Name of Agency/Person: ____
Address: ____
Phone: ____________________________________
Email: ____
Fax: ____________________________________

The following information:

☐ Assessment(s)	☐ Demographic Information
☐ Discharge/Transfer Summary	☐ Psychiatric Evaluation
☐ Diagnosis or Diagnoses	☐ Psychotherapy Note(s)
☐ Continuing Care Plan	☐ Treatment Plan or Summary
☐ Psychosocial Evaluation	☐ Current Treatment Update(s)
☐ Progress Note(s)/Treatment Progress	☐ Presence/Participation in Treatment
☐ Psychosocial Assessment(s)	☐ Educational Information
☐ Other: ________________________	☐ Other: ________________________

Name: ______________________________________ DOB: ______________________

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.

Sensitive Diagnoses: Review and, if appropriate, complete when release is for any purpose other than treatment:

I request and authorize Mending Mind Wellness, LLC to release and/or obtain the information pertaining to the condition(s) below for both the treatment and non-treatment purpose(s) listed in this authorization.

☐ Drug Abuse ☐ Alcoholism or Alcohol Abuse	☐ Sickle Cell Anemia ☐ Human Immunodeficiency Virus (HIV)

I understand that information on these sensitive diagnoses may be released for treatment purposes with me checking the above boxes and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

- ☐ I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.

AUTHORIZATION: I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature: ___________________________________ Date: _______________

Witness Signature: _______________________________ Date: _______________