MINDS that MATTER

Dr. Poonam Khanna, D.O.
Child, Adolescent & Adult Psychiatry

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Patient Name: _____ Patient DOB: _____

Consent to Release Protected Health Information

The undersigned patient or responsible party (parent, legal guardian, or conservator) hereby consents to, and authorizes, Dr. Poonam Khanna, D.O., to have bilateral exchange of information contained in the medical records of the above listed patient with:

Name: _____ Phone: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

This information is requested for the purpose of :

_____ continuing care and/or treatment
_____ other:

This information will be limited to:

_____ Psychiatric/medical/alcohol/drug abuse evaluation
_____ Psychiatric/medical/alcohol/drug abuse discharge summary
_____ Progress notes
_____ Psychotherapy notes
_____ Lab studies
_____ Medical tests/studies
_____ Psychological testing
_____ Educational testing
_____ School performance
_____ Other:

He/she understands that he/she has the right to cancel this Consent at any time by sending a signed and dated written request to Minds that Matter indicating the desire to cancel. He/she understands that once the information has been released to the above listed entity the recipient might re-disclose it, Minds that Matter/Dr. Poonam Khanna has no control over it, and privacy laws may no longer protect it. He/she understands that an additional consent must be obtained for information to be exchanged or disclosed to any other entity. He/she understands that he/she is entitled to a copy of this Consent, upon request.

_____ _____
Signature of Patient, Parent, Legal Guardian or Conservator Date signed

_____ _____
Printed Name of Patient, Parent, Legal Guardian or Conservator Relationship to Patient