Peaceful Mind
COUNSELING SERVICES

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

ADDRESS/PHONE

Client Name: _____ Date of Birth: _____/_____/_____

Address:_____

Street Apt # City State Zip

SEND RECORDS TO/FROM

Name of person or Facility: _____

Address: _____

Street Apt # City State Zip

Phone Number :(_____)_____-_____ Fax Number:(_____)_____-_____

Specific description of the information to be disclosed:

____Demographics
____Med Consent
____Discharge Summary
____Lab Report
____MD Evaluation
____LCSW Evaluation
____Full medical record
____MD Progress Notes
____LCSW Progress Notes
____MD Treatment Plan
____LCSW Treatment Plan
____Other:_____

Specific description of the purpose of the disclosure:

____Continued patient care
____Disclosure at patient request
Other (specify):_____
_____

I authorize the provider to use or disclose information related to: (must be initialed) REQUIRED

____Behavioral Health care/Psychiatric Care
____Insurance Coverage (COB)
____I consent to the release of information created within 12 months before/after the date this authorization was signed

I understand that Peaceful Mind Counseling Services (PMCS) will not condition treatment on my signing this authorization. PMCS will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I understand that I may revoke this authorization at any time, unless the disclosing party has already relied on my authorization to disclose health information. To revoke my authorization, I must submit a written request to PMCS. Unless I revoke this authorization earlier, it will expire one year from the date of signature. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person/organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herin.

_____ _____

Signature of Client Date

If you are not the client, but are signing on behalf of the client, please complete the following:

_____ _____

Printed name Relationship to client (**Legal guardian ONLY**)

_____ _____

Signature Date