Peaceful Mind Counseling Services
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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	____MD Evaluation	____LCSW Progress Notes
____Med Consent	____LCSW Evaluation	____MD Treatment Plan
____Discharge Summary	____Full medical record	____LCSW Treatment Plan
____Lab Report	____MD Progress Notes	___Other:_____

Specific description of the purpose of the disclosure:

____Continued patient care Other (specify):_____

____Disclosure at patient request _____

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