

Consent for Release of Patient Information

Client Name: _____ DOB: _____ Chart #: _____

Email: _____

I hereby authorize **Mindpath Health** to... **release** **obtain**

specified information in my medical/client/educational record for the purpose of continued mental health care.

(Individual, Facility, or Organization)_____
(Address)_____
(Phone Number)_____
(Fax Number)

This data shall include the available items checked below:

- | | |
|---|--|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Telephone Communication Only | <input type="checkbox"/> Laboratory Results |
| <input type="checkbox"/> Admission Summary | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Progress/Treatment Notes | <input type="checkbox"/> Educational Testing |
| <input type="checkbox"/> Initial Evaluation | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Medication Log | <input type="checkbox"/> Other _____ |

Dates of Treatment:

From: _____ To: _____

Disclosure and/or exchange of the protected health and account information as authorized above may include communication by phone, fax or mail. This disclosure and/or exchange may include information regarding drug, alcohol or sexual abuse, psychological or psychiatric impairments, HIV and/or AIDS or other physical conditions. If the authorized individual or entity that receives or releases this information is not a health insurance plan or health care provider covered by federal privacy regulations (HIPAA), the released information may be re-disclosed at will by the recipient or sender without the consent of the patient or guarantor and may no longer be protected by federal or state law. *If I refuse to sign this form, I understand that it will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or eligibility for health benefits.* Unless otherwise revoked in writing, this authorization will automatically expire one year from the date signed.

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- Diagnosis of a Substance use disorder.

I have read and understood the above statements and I consent to the release of the protected health and account information as indicated above. I also understand that there may be costs incurred with this request. Any such costs will be in compliance with State copying laws.

Client (or Guardian's) Signature_____
Witness_____
Date

If you have additional questions regarding your request please
contact our Medical Records Department for assistance.

Phone: 855-979-5627

Fax: 855-365-7163

medical.records@mindpathcare.com