AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client Name: _____ DOB _____

I, _____, hereby freely and voluntarily authorize Mindful Collaboration located at 5003 Southpark Dr. Ste. 220 Durham, NC 27713 to release/disclose my protected health information to, and/or obtain protected health information from:

_____
Name

_____
Address

_____
Telephone Number

The purpose of this disclosure is for:

____ Treatment planning
____ Referral/Coordination of Care
____ Discharge Planning
____ Other (specify) _____

Information to be disclosed:

____ Treatment progress summary
____ Psychological testing results
____ Progress note documentation
____ Psychiatric Evaluation
____ Diagnosis
____ Academic/Intelligence testing results
____ Treatment/Service Plan
____ Discharge summary
____ Medical History and Physical
____ Other (specify)_____

My right to confidentiality has been explained to me. I understand the information to be released, the purpose of the release, and the regulations protecting my confidentiality. I understand that the provision of services is not contingent upon my agreement to sign an authorization for the disclosure of protected health information. I understand that my medical record may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, or a communicable or venerable disease. I understand that such information is confidential and is protected by federal law. I understand that the above recipient, without my further consent, may not release this information. I understand that the potential exists for protected health information that is released with my authorization to be re-disclosed by the recipient, and thus Mindful Collaboration no longer has control over my privacy with regard to the recipient of the information. I understand that I may revoke my consent at any time, in writing, and that after one year from this date the consent will automatically expire.

_____ _____
Signature of client (or person acting for client) Date

_____ _____
Signature of therapist Date

___ Copy accepted by client ___Copy kept by therapist