mind matters, P.C.

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Authorization to Use/Disclose Health Information

Regarding patient: _____DOB_____

I authorize Mind Matters, P.C. to (initial all that apply)

_____ Release Information to the person/party listed below

_____ Receive Information from person/party listed below

Name: _____

Address: _____

_____

Phone number: _____ Fax number:_____

Initial by all authorizations that apply:

_____ Medical/Mental Health Diagnosis

_____ Diagnostic Reports (lab, EKG, etc.)

_____ Psychotherapy Notes

_____ Substance Abuse information

_____ Past/Present Medication

_____ Progress Notes

_____ Genetic Testing

_____ School Information

_____ HIV information

_____ Other (specify)_____

Reason for Disclosure

_____ Continuity of Care _____ Transfer of Care_____ Referral_____

Other (specify)_____

I may revoke this authorization at any time by notifying Mind Matters, PC in writing of my in writing of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by Mind Matters P.C. before written notice is received. Unless earlier revoked, this authorization will expire 2 years from the date of signature or as otherwise specified:_____

Patient Name_____

Patient Signature _____ Date_____