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AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Regarding patient:

_____ DOB _____

I authorize Mind Matters, PC to: ____Release information to, and/or

____Receive information from:

Name: _____

Address: _____

Phone and Fax number: _____

____**Primary Care Physician** ____**Other**(specify)_____

Information to be Disclosed: (Initial all 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 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, PC before the written notice is received. Unless earlier revoked, this authorization will expire 2 years from the date of signature or as otherwise specified_____

Signature_____Date_____

Patient or Parent/Legal Guardian (if patient is a minor)

Print Name_____