STATE OF MIND WELLNESS CENTER

2629 Townsgate Road • Suite 210 • Westlake Village, CA • 91361
805-835-4401 805-835-4909 • www.stateofmindwellness.center

Authorization for the Release/Exchange of Protected Health Information

By signing this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

Patient Name: _____ Date of Birth: _____

☐ I authorize my provider to: ☐ RELEASE ☐ RECEIVE psychological/psychiatric mental health information to/from the SECOND PARTY as directed below:

Second Party:

Provider Name: _____ Phone: _____ Fax or Email: _____

Address: _____ City & State: _____ Zip Code: _____

Type of Information to be Disclosed:

☐ I authorize disclosure of all health information, including information relating to medical, pharmacy, mental health, substance abuse, and psychotherapy; or

☐ I authorize only the disclosure of the following information: _____

Purpose:

☐ My health information is being disclosed at my request or at the request of my personal representative; or

☐ My health information is being disclosed for the following purpose: _____

Effective Period:

☐ This authorization for the release of information covers all past, present, and future time periods of healthcare; or

☐ This authorization for the release of information covers the period of healthcare from: _____ to _____

I understand that treatment, payment, enrollment in a health plan, or eligibility and benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my provider authorization to disclose my records. I understand that I may revoke this authorization at any time by providing a written notice to my provider, however, the revocation will not have an effect on any actions taken prior to the date my revocation is received. I understand that my information may be re-disclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement.

_____ _____

Patient/Guardian Signature Date