Client Name: _____

Date of Birth: _____

I authorize Mind, Body, and Soul LLC to:

- ☐ Send
- ☐ Receive
- ☐ Send and Receive

The Following information:

- ☐ Medical History and Evaluation(s)
- ☐ Developmental and/or Social History
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ All of the Above (Medical History and Evaluation(s), Mental Health Evaluation(s) Developmental and/or Social History, Educational Records, Progress Notes, Treatment Summary, Discharge Summary)
- ☐ Mental Health Evaluation(s)
- ☐ Educational Records
- ☐ Treatment Summary
- ☐ Other: _____
  _____
  _____
  _____

To/From (Name of Person or Agency receiving or providing information):

_____

Phone Number of Party Receiving or Providing Information:

_____

Address of Party Receiving or Providing Information:

_____

Your Relationship to Client:

- ☐ Self
- ☐ Parent/ Legal Guardian
- ☐ Personal Representative
- ☐ Other _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature: _____ Date:_____

Witness Signature (If Client is unable to Sign): _____ Date:_____