

Serene Minds, LLC

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Complete this form if you would like Serene Minds to obtain records from your primary care provider or your previous behavioral health provider.

I, _____ (name) Date of Birth: _____

SSN: _____ Previous name: _____; authorize Serene Minds, LLC to request &/or release health care information from/to:

Name and Organization: _____
Relationship to Client: _____ Fax #: _____
Address: _____
City & State: _____ Zip Code _____ Phone #: _____

Release the following information:

_____ Health care information relating to the following treatment or condition: _____
_____ Health care information for the date(s) below: _____
_____ All health care information

The purpose of the disclosure:

Progress with TX Medication review compliance with TX
 Request for records Interagency collaboration Other: _____

This authorization will expire when treatment is discontinued or the following occurs: _____

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are two ways to cancel this authorization:

- 1) Write, sign and date a letter to the clinician to cancel the authorization; or
- 2) Sign, date and write "CANCEL" on this original form

Once the provider gives out the information, the provider has no control over it. The recipient might disclose it. Privacy laws may no longer protect it. I acknowledge that I am signing this consent in the absence of coercion, duress or deceit. I also agree to the release of health care information regarding testing, diagnosis, and/or treatment for the following: HIV/AIDS status, Sexually transmitted diseases, Psychiatric/mental health disorders, and/or Drug/Alcohol Usage.

I understand that my mental health, substance use or other addiction disorder issue records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. The consent shall be valid only for the period reasonably necessary to accomplish the purpose for which it was given. I understand that in generality, a treatment program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Client/Legally Authorized Individual Signature Date Relationship to Client

Witness Signature for Consent to Release of Information _____