Serene Minds, LLC

410 Foulk Road, Suite 102
Wilmington, DE 19803

Phone: (302) 478-6199
Fax: (302) 384-7162

80 Omega Dr Bldg C
Newark, DE 19713

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Complete this form to authorize Serene Minds to release and/or obtain protected health information from your clinical record to/from the person/agency indicated below

I, _____ (name) Date of Birth: _____Previous name (if any) _____

authorize Serene Minds, LLC to release and/or obtain protected health information for myself or my minor child _____ (Child's name) Date of Birth:_____to/from ☐Primary care provider ☐Psychiatrist ☐Therapist ☐Teacher ☐Other_____ (Check one box)

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

I authorize the release/exchange of the following information:

☐ *Health care information relating to the following treatment or condition:* _____
_____
☐ *Health care information for the date(s):* _____
☐ *All health care information*
☐ *Phone conversation only without exchange of written medical information* _____
☐ *Other* _____

The purpose of the disclosure:

☐ Progress with TX ☐ Medication review ☐ Compliance with TX
☐ Request for records ☐ Coordination of care/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 redisclose 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