Child Mind Institute

Authorization for Release of Protected Health Information

_____   _____

Print Name of Patient   Patient Date of Birth

When this optional form is completed and signed by you, it authorizes the Child Mind Medical Practice, PLLC and Child Mind Medical Practice, PC (together, "the Practice") to _receive or disclose_ protected health information from your clinical record _from or to_ the person designated on the form. _A new form must be completed and signed for each person you wish to designate._

I, _____, hereby authorize the Practice to (check all that apply):

Patient / Legal Guardian's Name

_____ **Receive** my protected health information **from**:

_____ **Disclose** my protected health information **to**:

Person or entity the Practice may contact:

Name: _____

Address: _____

Phone: _____

E-mail: _____

I am requiring the release of this information for the following reasons: _____.

Information to be disclosed (check all that apply):

Complete Medical Record	_____	Billing Records	_____
Psychiatric Evaluation	_____	Reports	_____
Neuropsychological Evaluation	_____	Other (specify) :	_____

Please specify any limitation for this release or any information you do NOT authorize for release: _____.

I understand that my clinician cannot re-disclose information received from another health care provider unless that other provider permits. I understand that information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

This authorization shall remain in effect until (check one):

o   _____, 20_____ (insert specific date)
o   until the patient identified above is no longer receiving care from the Practice
o   _____ (insert a specific event that relates to the purpose of this disclosure)

You have the right to revoke this authorization in writing at any time by sending such written notification to the Practice. Your revocation cannot be retroactive.

*if parents are separated or divorced and have joint custody of the patient, both parents' signatures are required.

_____   _____   _____   _____
Signature   Print Name   Relationship to Patient   Date

_____   _____   _____   _____
Signature   Print Name   Relationship to Patient   Date