MIND Therapy CLINIC
INNOVATIVE MEDICINE, PERSONALIZED CARE

RELEASE OF INFORMATION CONSENT

Name:	DOB:	Phone:	Zip:
Address:		City:	State

I, ________________________________, authorize Mind Therapy Clinic, provider of my psychiatric care, to: ☐ Send ☐ Receive my records ☐ To ☐ From

Name:	Entity:	Phone:	Fax:
Address:			

If releasing my records to Mind Therapy Clinic, please send to 240 Tamal Vista Blvd., Suite 160, Corte Madera, CA 94925.

INFORMATION TO BE RELEASED*

☐ Evaluation	☐ Lab Results	☐ Progress Reports	☐ Medication Info
☐ Testing Results	☐ Diagnosis	☐ Summary Reports	☐ Entire Record

The above information will be used for the following purposes only:

☐ Planning Treatment	☐ Continuing Treatment	☐ Case Review	☐ Updating Files

I understand that this information may be protected by Title 42 (CFR, 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 the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by the state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice. This release will **expire one year** from the date of signature. 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.

Patient or Representative's Signature:	Date:
Basis for Representation:	

***If your information to be released and/or purposes for the information to be released are not listed as one of the selection choices on this form, please add it to the back of this sheet.**