mindful therapy group

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Instructions: This form must be completed for any person or organization that you want Mindful Therapy Group to be able to share scheduling, billing, payment, or clinical information with. If you will be handling all the coordination of your care independently, then in most cases a Release of Information does not need to be completed. **This form must be completed and signed by the client.**

Important for Clients Under 18: Under Nevada state law (Nev. Rev. Stat. § 129), parental consent is required for mental health treatment and parent/guardian consent is required to authorize the release of records. Thus, unless the minor is emancipated, this form must be completed by the parent/guardian.

If you have any further questions regarding this document, you can refer to our Release of Information FAQ page on the Mindful Therapy Group Website.

Patient Name: _____

DOB: _____

At my request, I hereby authorize Mindful Therapy Group, P.C. and my mental health provider(s), to disclose my private health information to the recipient specified below.

Please check and fill in selections below
My entire treatment record: ☐
Billing information, including dates of service, diagnostic codes, and procedure codes: ☐
Scheduling and Appointment Details: ☐
Patient Portal Access (billing statements, appointments, and progress notes will be viewable): ☐

Records from a specific timeframe: _____

Other: _____

All of the above: ☐

Information to be exchanged with

Name of external facility or individual: _____

Relationship to Client: _____

Address: _____

Fax: _____

Phone: _____

Email: _____

Unless specified otherwise below, this authorization of disclosure of my health information will expire at the conclusion of my treatment with Mindful Therapy Group.

Optional specific expiration date or event: _____

I understand and agree that:

- This authorization is voluntary;
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider, except to the extent that the information being requested may assist your health care provider in determining appropriate treatment.
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- I may revoke this authorization at any time by notifying my provider in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed nor future disclosures to the extent that action has already been taken in reliance on this authorization.

Authorization

Signature of Patient or Authorized Representative: _____

Date: _____

Relationship if not Patient: _____