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 Texas state law, individuals under age 18 typically require parent or guardian consent for behavioral health treatment. Certain minors may consent to their own care under specific circumstances (e.g., if they are emancipated, married, living apart and financially independent, or seeking treatment for substance abuse, pregnancy-related care, or certain communicable diseases).

If you are a minor who meets the legal criteria to consent to your own care, you must complete this Release of Information form yourself to authorize Mindful Therapy Group to share your information with others, including parents/guardians that call in to coordinate scheduling, payments, or other requests on behalf of their child. If you do not meet one of these criteria, your parent or legal guardian must complete this form on your behalf.

For more information on Texas law, please refer to Texas Family Code Chapter 32.

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 Support Services, Inc., dba Mindful Therapy Group, 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:

The information to be disclosed specifically **does** include (check all that apply):

Psychotherapy notes:
Information related to substance abuse assessment and treatment:

Recipient Information

Name of Provider/Facility/Recipient:
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: