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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I_____ authorize Mindset Counseling Solutions to:
_____release to:
_____obtain from:
_____exchange with:

Name: _____

Address: _____

_____

Phone/Fax/: _____

The following information pertaining to myself:
____ progress letter(s)
_____diagnosis
_____psychological test results
_____psychiatric evaluation/medication history
_____dates of treatment attendance
_____verbal communication
_____other (specify)_____

For the purpose of:
_____coordinating treatment efforts
_____other (specify)_____

____ (initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Mindset Counseling Solutions.

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Mindset Counseling Solutions will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier dates, condition, or event_____. I understand I have the right to refuse to sign this form and that I may revoke my consent at any time (except to the extent that that information has already been released).

_____ _____ _____
Signature of Client (or guardian if minor) Date Date of Birth

_____ _____
Signature of Witness Date