MindPath Care Centers

CONSENT FOR RELEASE OF CLIENT INFORMATION

Client Name: _____ DOB:_____ Chart #: _____

Email:_____

I hereby authorize **MindPath Care Centers** to… ☐ **release** ☐ **obtain**

specified information in my medical/client/educational record for the purpose of continued mental health care.

_____
(Individual, Facility, or Organization)

_____
(Address)

_____ _____
(Phone Number) (Fax Number)

This data shall include the available items checked below:

☐	All Records	☐	Discharge Summary
☐	Telephone Communication Only	☐	Laboratory Results
☐	Admission Summary	☐	Psychological Testing
☐	Progress/Treatment Notes	☐	Educational Testing
☐	Initial Evaluation	☐	Billing Records
☐	Medication Log	☐	Other_____

Dates of Treatment:

From: To:

Disclosure and/or exchange of the protected health and account information as authorized above may include communication by phone, fax or mail. This disclosure and/or exchange may include information regarding drug, alcohol or sexual abuse, psychological or psychiatric impairments, HIV and/or AIDS or other physical conditions. If the authorized individual or entity that receives or releases this information is not a health insurance plan or health care provider covered by federal privacy regulations (HIPAA), the released information may be re-disclosed at will by the recipient or sender without the consent of the patient or guarantor and may no longer be protected by federal or state law. *If I refuse to sign this form, I understand that it will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or eligibility for health benefits.* Unless otherwise revoked in writing, this authorization will automatically expire one year from the date signed.

☐ Diagnosis of a Substance use disorder.

I have read and understood the above statements and I consent to the release of the protected health and account information as indicated above. I also understand that there may be costs incurred with this request. Any such costs will be in compliance with State copying laws.

_____ _____
Client (or Guardian's) Signature Witness

_____
Date

If you have additional questions regarding your request
please contact our Medical Records Department for assistance
Phone: 919-792-3942
Fax: 855-365-7163
medical.records@mindpathcare.com