

Authorization for Release of Mental Health Treatment

I, _____ [Insert Name of Patient/Client], whose Date of Birth is _____,

authorize **Mindful Solutions NJ, LLC** to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Contact information of person or organization:

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

- | | |
|---|---|
| _____ Assessment | _____ Educational Information |
| _____ Diagnosis | _____ Discharge/Transfer Summary |
| _____ Psychosocial Evaluation | _____ Continuing Care Plan |
| _____ Psychological Evaluation | _____ Progress in Treatment |
| _____ Psychiatric Evaluation | _____ Demographic Information |
| _____ Treatment Plan or Summary | _____ Psychotherapy Notes* |
| _____ Current Treatment Update | (*Cannot be combined with any other disclosure) |
| _____ Medication Management Information | _____ Other _____ |
| _____ Presence/Participation in Treatment | |
| _____ Nursing/Medical Information | _____ Initial in agreement to all checked |

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I have the right to request a copy of this authorization for my records.

Signature of Patient/Client

Date

Signature of Parent, Guardian or Personal Representative

Date

Signature of Staff Witness

Date