Mind Mechanix, LLC

Authorization for Disclosure and Release of Medical and Mental Health Information

Name:_____ D.O.B:___-___-___ Phone:_____-_____-_____
(Print)

Address: _____
(Street) (City) (State) (Zip Code)

I hereby authorize Mind Mechanix, LLC to:

☐ Release information to ☐ Receive information from ☐ Exchange information with

_____
(Person/facility, address, phone, fax which has medical and/or mental health information)

Type of disclosure: ☐ Verbal/Written/Electronic ☐ Copies of record ☐ Letter

Purpose of disclosure: ☐ Ongoing treatment ☐ Academic ☐ Support ☐ Other_____
(specify)

By initialing below, you are authorizing the following information to be released:

(Initial) **All counseling/mental health information.** Additionally, all information regarding Alcohol and/or Drug Abuse or HIV/AIDS results will be released **unless restricted in limitations below**.

(Initial) **All medication management services information medical information** (This may include but is not limited to drug/alcohol and mental health information transmitted by prescriber).

Limitations, if any, upon disclosure: _____

Type(s) of information: ☐ Initial Assessment ☐ Treatment Summary ☐ Attendance

☐ Psychiatric evaluation/medication history ☐ Other_____
(Specify)

If treatment is for substance abuse, I understand go to that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that my records are also currently protected under the federal privacy law regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 & 164. I understand that my health information specified above will be disclosed pursuing to this authorization, and that the recipient of the information may we disclose the information and it made no longer be protected under the age HIPAA privacy law. The Federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CRF Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure. I understand that the covered entity seeking this authorization is permitted under the HIPAA regulations, in accordance with 45 CFR section 154. 508(b)(4), to condition my signing of this authorization on the provision of treatment, payment, enrollment or eligibility for benefits, and that by refusing to sign this authorization, I may be responsible for payment of services and/or may not be able to receive services.

ACKNOWLEDGEMENT OF UNDERSTANDING:

I understand the expiration date of this authorization is___or 1 year from today's date, whichever is sooner. I understand that I may revoke this authorization at any time and it will be effective on the date notified except to the extent action has already been taken in reliance on it. I understand that if I have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality law. I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it. I understand that a photocopy or fax of this form is the same as the original.

_____ _____
Signature of Client (over 14 only) *Date*

_____ _____ _____
Signature of Legal Guardian (for clients under 18) *Relationship* *Date*

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