



Mind Mechanix, LLC



Authorization for Mental Health Treatment, Disclosure, and Release of Records to School

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

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

I hereby authorize Mind Mechanix, LLC to provide psychotherapy services to my child, _____, within the school setting. Please allow any provider from Mind Mechanix, LLC visitation and privacy to meet with my child, as requested.

In addition, I hereby authorize Mind Mechanix, LLC to:

Release information to Receive information from Exchange information with

(Person/School, address, phone, fax)

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:

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).
(Initial)

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 anytime 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.

Minor Signature (14 or older)

Date

Signature of client/legally responsible person

Relationship

Date