A TRAUMA-FOCUSED COUNSELING PRACTICE

6502 Bandera Rd Ste. 202B | San Antonio, TX 78238
T: 210.418.2546 F: 210.429.7242 hmbhsa.com

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

______________________________	____________________	____________________
Print Patient Name	Date of Birth	Social Security Number

I hereby authorize Healing Minds Behavioral Health, PLLC to disclose the individually identifiable health information as described below, which may include psychiatric, psychological, social, emotional, family, and educational information, as well as psychotherapy information (session reports, assessments, testing, social histories, professional consultations, referrals, diagnoses, goals, treatment plans, and other treatment of the client and the client's family). I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my child's health care and the payment for my child's health care will not be affected if I do not sign this form. I also understand that if I do not sign this form, federal and state law will prohibit Healing Minds Behavioral Health, PLLC from releasing records regarding his/her treatment of me/my child to the designated Recipient.

By accepting the records pursuant to this Authorization, the Recipient acknowledges and agrees that the protected health information covered by this release is confidential, privileged and protected by federal and state privacy statutes and regulations (excluding covered entities, eg. Insurance companies or health care provider), and agrees that Healing Minds Behavioral Health, PLLC's release of the individual identifiable health information will continue to be protected by federal and state privacy statues and regulations.

Date(s) of service (if known): ____

Description of information to be released: (check all that apply)

____ Entire Record
____ Evaluation Reports
____ Billing Records
____ Treatment Plan
____ Psychotherapy Notes
____ Other: ____

The individually identifiable health information described herein shall be released to:

____
Name (e.g., an individual, professional, school, or agency)

____
Address, if known

____
Contact Number(s), if known

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I intend for this Authorization to remain in full force and effect until I revoke it in writing. Further, it is my intent that a copy of this Authorization shall have the same effect as the original.

I understand that I may revoke this authorization at any time by notifying Healing Minds Behavioral Health, PLLC in writing at 12274 Bandera Rd. Suite #120 Helotes, TX. 78023.

______________________________________ ____________________

Signature of Client or Client's Representative Date

______________________________________ ____________________

Printed Name of Client or Client's Representative Date

____

Relationship to Client

______________________________________ ____________________

Witness Date