young mind center

Authorization to Release/Exchange Protected Health Information

Name: _____ Date of Birth: _____
print name of client

Parent/Guardian: _____ Home Phone: _____
print name of individual providing authorization

Address: _____
street / city / state / zip code

I hereby authorize the Young Mind Center to:

O release confidential information to the following individual/agency
and/or
O obtain confidential information from the following individual/agency

To: _____
agency name and/or professional's name title phone number

Address: _____
street / suite #

_____
city / state / zip code

Phone: _____ Fax: _____

Specific Information Authorized: (select one or more as appropriate)

O Psychological O Educational O Medical O Other: _____

I hereby authorize the exchange, mutual use, and/or disclosure of the information described above between the Young Mind Center and the agency and/or professional listed above.

This authorization will expire: O One year from this date.
O On _____
specify date or condition of expiration
O Upon written request to revoke authorization.

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to the Young Mind Center, except where a disclosure has already been made in reliance on my prior authorization.

Name: _____
print name of parent/guardian or adult client signature date