

Peace of Mind Counseling LLC
Release/Request for Health Information

Patient Name

Date of Birth

I hereby consent and Authorize:

Peace of Mind Counseling LLC

301 Thelma Dr. Suite 222

Casper, WY 82609

307-262-5810

To release to

Name: _____

Receive from

Address: _____

Relationship to PT _____

I understand that the information to be released includes information regarding **Medical, Mental Health, Chemical Dependency, and HIV/AIDS** conditions.

Each item below to be released MUST be INITIALED to be valid.

I authorize the following information to be released/requested.

___ DISCHARGE SUMMARY

___ PSYCHOLOGICAL TESTING

___ PSYCHIATRIC EVALUATION

___ MEDICATION INFORMATION

___ HISTORY/PHYSICAL EXAM

___ TREATMENT PLAN

___ LABS/X-RAY/EKG/MRI/EEG (including HIV/AIDS) ___ EDUCATIONAL EVALUATIONS

___ CONSULTATIONS

___ VERBAL COMMUNICATIONS

___ PHYSICIAN OUTPT NOTES

___ OTHER (Specify) _____

I AM AWARE THAT THESE DOCUMENTS WILL CONTAIN VERY DETAILED, SENSITIVE, INFORMATION ABOUT MYSELF OR THAT OF MY CHILD, INCLUDING FAMILY HISTORY; LEGAL HISTORY; SOCIAL HISTORY; MEDICAL HISTORY AND TREATMENT HISTORY; AND HIV/AIDS

Purpose:

I understand that the information will be used for:

___ Further Evaluation and Treatment

___ Other _____

I understand that my behavioral health treatment records(including drug and alcohol) and information are protected under the federal regulations governing Confidentiality and Behavioral Health Patient Records, 42 CFR, Part 2,and the HIPPA Privacy Rule, 45CFR, Parts 160 and 164, and cannot be disclosed without my written authorization, unless otherwise provided for by the regulations I hereby release both the above parties from any liability which may result from furnishing the information released and requested. Without my expressed written revocation, this consent will expire in SIX (6) months from the date signed.

If the patient is under the age of 18 and has had drug and/or alcohol diagnosis, treatment or education, Federal Regulations require us to obtain the signature of BOTH the minor and parent/guardian.

_____	_____	_____	_____
Patient Signature	Date	Signature of Legal Guardian	Date
_____	_____		
Witness	Date		