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.

____ DISHARGE 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, INFORMAITON 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, <u>Federal Regulations</u> require us to obtain the signature of BOTH the minor and parent/guardian.

_____	_____	_____	_____
Patient Signature	**Date**	**Signature of Legal Guardian**	**Date**

_____	_____
Witness	**Date**