LumenMind
PSYCHIATRY
Holistic Mental Wellness

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Release of Information Form

Name of Provider / Agency

Practice Address

Phone _____ **Fax** _____ **Email** _____

Release of Information

I hereby authorize _____

☐ Release information to ☐ Obtain information from ☐ Exchange information with

Name

Address

Phone Number _____

The information requested or authorized for release or exchange pertains to:

☐ Mental Health ☐ Mental Health Counseling / Psychotherapy
☐ Education ☐ HIV / AIDS
☐ Sexually transmitted diseases ☐ Drug or alcohol abuse

This authorization is valid until _____ . I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form, or by sending a written, signed, and dated request to the provider named above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my provider has no control over it, and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

Patient's Name _____ **Date of Birth** _____

Patient's Signature _____ **Date** _____

Parent's Signature (if patient is a minor) **Date** _____

Guardian's Signature _____ **Date** _____

This is a HIPAA authorization for release of protected health information. It is a starting template and must be reviewed by the practice and its counsel before use.