

CENTER FOR HEALING & HAPPINESS, PC

(734) 459-1760 Office

(734) 459-1797 Fax

NAME: _____

DATE OF BIRTH: _____

BEHAVIORAL HEALTH PROVIDER AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

Patient Consent to Release/Exchange Medical Information (to be completed by patient or parent/guardian)

I, _____, _____, authorize the exchange of information between the
(Patient Name) (Date of Birth)

Center for Healing and Happiness, PC and:

Name

Address City State Zip

Telephone Number / Fax Number

To release/exchange information regarding: _____

For the following purpose: _____

I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. Information exchanged may include information on mental health care, HIV status, substance abuse care, diagnosis, treatment, and psychotherapy notes. The information disclosed pursuant to the authorization may be redisclosed by the recipient and no longer protected by the federal privacy regulations.

Patient/Parent/Guardian Signature

Date