Better Minds
Psychology

2320 Harts Bluff Rd.
Mount Pleasant, TX 75455
903-434-7068

Authorization for Release of Information

I authorize the following protected health information to be released from the medical record of:

_____	_____	_____
Last Name	First Name	Date of Birth

_____
Phone Number

I authorize Better Minds Psychology, PLLC to: (choose one or both options)

_____ Release patient PHI

AND / OR

_____ Obtain patient PHI from:

Name/Organization: _____

Address: _____

Phone Number: _____ Fax Number: _____

Information to be released (check all that apply):

_____ Entire medical record
_____ Dates of Service
_____ Diagnosis Only
_____ Intake
_____ Progress Notes
_____ Diagnosis and Treatment Plan Only
_____ Summary of Treatment and Progress
_____ Psychological Testing Results
_____ Other: _____

Purpose of Release

_____ Coordination of care _____ Transfer of care _____ Request of the Patient

_____ Other: _____

I understand that this authorization is valid for one year unless you enter a different date of expiration here: _____. I may revoke this authorization in writing at any time except to the extent that Better Minds Psychology, PLLC has already relied on this authorization. I may revoke it by mail a written notice to the address above stating my intent to revoke this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

Your signature indicates that you have read and understand this form and authorized release of your information as described above. You understand that you may refuse to sign this authorization and that refusal to sign will not affect treatment.

_____ _____

Client Signature Date

_____ _____

Provider Signature Date