Consent to Obtain and Release of Information

Name: _____Date of Birth: ____-____-_____
Address:_____
City\State:_____ Zip-Code:_____
Telephone:_____
Parent/Guardian:_____
Parent/Guardian Address: _____

I hereby authorize Mood Food Wellness and the following individuals or agencies to share written and oral information about my needs and services stipulated below.

Name/Agency
_____
_____
Types of information to be released is:
_____
_____
The purpose of the disclosure authorized is to:
_____
_____

SPECIFIC AUTHORIZATION FOR RELEASE

I specifically authorize the release of:
- □ Mental health records — Initial _____
- □ Substance abuse records — Initial _____
- □ HIV/AIDS information — Initial _____
- □Transmit information electronically (fax or e-mail) — Initial _____

I understand that my health care records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C § 132d *et seq.*, 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time, either orally or in writing, except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as follows:_____

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

_____ _____
Patient/Representative Signature Date

_____ _____
Representative's Relationship to Patient Witness

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