

Authorization and Consent to Release Medical Information

Jami Dickson, APRN, PMHNP-BC
Nancy Thompson, APRN, PMHNP-BC
Matthew Richardson, PA-C
Jackie Mahoney, LCSW

2411 Virginia Pkwy #7
McKinney, TX 75071
Phone: 972-712-0591
Fax: 972-421-1527

Date: _____

Patient's Name: _____ Date of Birth: _____

I authorize the above mentioned provider(s), whose office is located at the address listed above to disclose and/or obtain information from the following physician, psychiatrist, hospital and other treatment provider or organization, relative, friend, or any other person I choose to name below

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

By signing below I acknowledge that the following information may be released, discussed, or disclosed. If you agree to the release, please check the option you agree to.

- Complete Medical/Psychiatric Record
- Diagnosis and Medication Records
- Substance Abuse Information (including assessment and treatment records)
- Treatment Plan
- For Incoming or Outgoing Referrals
- Results of Labs/Tests: _____
- Correspondence Regarding: _____
- Other: _____

I am signing as a patient, guardian and/or responsible party. I further understand the records released may contain references to family and me. I further waive and release the above named parties from any liability resulting from the release of the above information. I also understand that my records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA. I also understand that I may revoke this authorization and must do so in writing and present this written revocation to the office of Total Mental Wellness. Unless otherwise revoked, this consent expires in 12 months from this date.

Signature: _____ Date: _____