MIND HEALTH INSTITUTE
MISSION VIEJO

# Consent & Authorization to Use, Disclose, and Receive Mental Health Information

I, _____ , hereby authorize _____
*(Name of patient)* *(MHI-MV provider)*

& the Mind Health Institute, Mission Viejo to *release, request* and *exchange* information and records obtained in the course of my diagnosis and treatment for the following purposes:

- Increase understanding of my previous history, diagnosis, and treatment
- Coordinate care on an ongoing basis with other providers that are also treating me
- Discuss my care with friends or family that may be important sources of support

Information can be released to, requested from, or exchanged with the following:

| *Name of individual/organization* | *Address* | *Phone number* | *Fax* |
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I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing and received by my provider to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

I understand that I have the right to refuse consent and/or signing of this authorization, and my provider shall not condition my treatment upon this refusal. I understand that I am voluntarily signing this form to release my health information to the party or parties designated.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information.

This authorization is effective immediately and shall remain in effect from date of signing unless explicitly revoked in writing.

Signature: _____ Date: _____
*(Patient, parent, or legal guardian)*

Please print name: _____Relationship to patient: _____

Witness: _____ Date: _____
*(MHI-MV provider)*