Patient Name: _____
Patient ID #: _____
Clinician: _____
Date Received: _____

Mindful Acceptance Therapies, L.L.C.
2202 Francis Street, Columbus, GA 31906
www.mindfulacceptancetherapies.com

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

None of the information or records obtained under this authorization may be re-released to another party.

_____ _____
Client Name Date of Birth

I, _____, hereby authorize _____ and/or his or her administrative and clinical staff to obtain or disclose (indicate) the following information:

____Confirmation of participation in therapy
____Psychological testing results
____Summary of evaluation findings
____Academic Records
____Behavior Rating Scales
____Treatment progress
____Treatment summary
____Psychotherapy notes (separate release)
____On-going consultation
____Other_____

Indicate if information is to be restricted from disclosure if you have paid for your care out-of-pocket:
Yes _____ No _____ N/A _____

This information is to be released for purpose of: psychological evaluation_____, treatment planning _____, to coordinate services_____, other _____

This authorization shall remain in effect until (give date or event): (until revoked)_____, (6 months) _____, (1 year) _____, other_____

This information should only be released to or obtained from:

_____ _____
Name Phone

_____ _____
Address FAX

_____

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent, Legal Guardian or Authorized Representative of Patient Relationship to Patient/Date

_____ _____
Date Witness

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.