HEALTHY MINDS PSYCHOLOGY ASSOCIATES
TUCKER: 3760 LAVISTA ROAD, SUITE 102, TUCKER, GA 30084
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AUTHORIZATION FORM TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully and complete this document. This form authorizes me to release protected information from your clinical record to the person/agency you designate.

Patient Name: _____ **Date of Birth:** _____

I authorize my psychologist or therapist at Healthy Minds Psychology Associates, to obtain/release the following:

❒Medical records	❒Treatment Records	❒Educational Records	❒Alcohol/Drug Information
❒Discharge Summary	❒Psychiatric Reports	❒Legal Documents	❒History/ Physical Exam
❒Psychological Report	❒Disciplinary Report	❒Diagnosis	❒Progress Notes
❒Consultation Report	❒Verbal Communication	❒Test Results	❒Other _____

The disclosure of information is required for the following purposes:

❒ Coordination of Treatment ❒ Referral to/from _____

❒ Collateral Information for Psychological Evaluation ❒Other (Please Describe)_____

This information should only be obtained from/released to the following: (Provide name, institutional affiliation and address of person from/to whom the information is to be obtained/released):

Name/Agency: _____

Address: _____

_____

Phone: _____

Fax: _____

The abovenamed parties, therapist & person(s) or entity (entities) designated above agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and submitted to Healthy Minds Psychology Assoc, 3760 Lavista Road, Suite 102, Tucker, GA 30084. This consent expires in twelve (12) months from the date of my signature below unless otherwise stated herein.

Signature(s)

_____ _____

Patient's Signature Date

_____ _____

For Minor: Parent/Legal Guardian Signature Date