Beautiful Mind Therapy, Inc
Phone: 708-695-4808 Fax: 888-965-7017
975 East Nerge Road, Suite W40, Roselle, IL 60172-4809

Authorization to Use or Disclose Client Records/Information

Patient Name: Date of Birth:

Address:

City: State: Zip Code: Phone:

Select one of the options below:

☐ I authorize the release of my health information **from (therapist name)** _____ to:

Individual or Organization's Name:

Address:

City: State: Zip Code: Phone:

☐ I authorize (Name of Healthcare Provider) _____

to release my health information **to (therapist name)** _____.

Purpose:

☐ Facilitation of Assessment
☐ Coordination of Treatment and Support
☐ Monitoring Progress
☐ Coordination of Payment for Professional Services Rendered
☐ All of the Above
☐ Other:

I understand that this information may be transmitted in the following mode (Please check all acceptable)
☐ Written ☐ Verbal ☐ Electronic ☐ Fax

This Release Ends:
☐ 1 year from date of last contact.
☐ Specific date:
☐ Specification event:
☐ Other:

I understand that above named therapist authorized to receive or exchange this information has the right to inspect and copy the information to be disclosed. I further understand that if the entity receiving this information is not a healthcare provider covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by privacy laws. Above named therapist is not accountable or responsible for such re-disclosures.

I understand that I may revoke this consent at any time providing a written revocation to the above named therapist. Your revocation will only apply to disclosures that have not already occurred. This consent will expire 12 months after the date of client termination unless another date is specified. For reimbursement purposes, this authorization shall remain in effect until full reimbursement for services has been received by this therapist.

It is my full understanding that the records and communication to be disclosed will include sensitive information such as evaluation, diagnosis, treatment information for mental health, developmental disabilities, alcohol or substance use/abuse, or HIV/AIDS unless specifically initialed by client for exclusion.

Patient Name: _____ Patient Signature: _____ Date: _____
(age 18 and older)

Patient Name: _____ Patient Signature: _____ Date: _____
(age 12 and older)

Parent/Guardian name:_____ Patient Signature: _____ Date: _____
(for client under age of 18)

Therapist Name: _____ Therapist Signature: _____ Date: _____