MindfulConnections
PSYCHOLOGICAL SERVICES

Authorization for Release/Exchange of Information

This form provides Mindful Connections Psychological Services, PLLC, the Provider or therapist, with written permission to communicate with other individual providers regarding your treatment (e.g. previous treating therapist, current health care providers, parents or school).

Client Name(s): _____

Client Date of Birth: _____

Release of information from Mindful Connections Psychological Services PLLC, to Another Person or Party Listed Below.

I authorize to release/exchange the following information to:

Full Name: _____

Phone Number: _____

Address: _____

City, State, Zip Code: _____

Information to be released: (*Please check all that apply*)

_____ Screening Information

_____ Behavioral and Psychological Reports

_____ Treatment Plan

_____ Other: _____

_____ Counseling Notes

_____ Coordination of Care

_____ Intake and History

This release with be valid until the termination of treatment or authorization from client to revoke.

Expiration date: _____

This authorization may be revoked at any time.

Name of Patient, Client, or Authorized person (print):

_____

Signature of Patient, Client, or Authorized person:

_____ **Date**: _____