POSITIVE FRAME OF MIND
COUNSELING PLLC

Release of Information & Consent Form

It is important that health care providers work together.

As such, I,________________________________, would like your permission to communicate, when necessary, with your medical providers and/or emergency contact.

Client Name: ____ **DOB:** ______ ___________________

Sponsor ID (if applicable): ____________________________**Phone:** ___________ ___________________

Address: ____

City:___________________________ **State:** ___________ **Zip:**______________

I, ____, hereby authorize the release and exchange of information specified below between:

Name/Title or Organization: ____ _____________

Name (i.e., Psychiatrist or Primary Care Physician): ___________________ ___________________

Date of Service: ____

Address:____ ______

Phone/Fax: ____ _____________

And

Positive Frame of Mind Counseling, PLLC

2304 Midwestern Pkwy, Ste 202

Wichita Falls, TX 76308

T-940-613-1661

F-940-228-0424

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This release of information will expire in 12 months from signing date.

This release of information shall be limited to the following specific types of information:

____ Assessment ____ Nursing/Medical Information

____ Diagnosis ____ Toxicological Reports/Drug Screen

____ Psychosocial Evaluation ____ Educational Information

____ Psychological Evaluation ____ Discharge/Transfer Summary

____ Psychiatric Evaluation ____ Continuing Care Plan

____ Treatment Plan or Summary ____ Progress in Treatment/Notes

____ Current Treatment Update ____ Demographic Information

____ Medication Management Information ____ Other
____

____ Presence/Participation in Treatment ____ Other
____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:
____

This authorization for release of information is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification to Positive Frame of Mine Counseling, PLLC in writing. However, a revocation is not valid to the extent that parties have acted in reliance on such authorization. The information is confidential and any redisclosure by the recipient is prohibited, unless expressly permitted by the patient or someone authorized to act on his/her behalf. I understand that this authorization authorizes

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the release of all medical records including Psychiatric, Alcohol, Drug Abuse, and AIDS records.

Client Name (Printed):______________________________________

Client Signature: ____ Date:__________

Witness Name (Printed):_____________________________________

Witness Signature: ____ Date: ___________