Release of Information & Consent Form

It is important that health care providers work together. As such, I Positive Frame of Mind Counseling PLLC, 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) **Clinic Name**

Organization/Address

Phone/Fax

and

Positive Frame of Mind Counseling PLLC
4245 Kemp Blvd, Ste 720
Wichita Falls, TX 76308
T-940-613-1661 F—940-228-0424

This release of information will be effective from _____ to _____. This release of information will expire in 12 months from begin date.

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

____ Assessment
____ Diagnosis
____ Psychosocial Evaluation
____ Psychological Evaluation
____ Psychiatric Evaluation
____ Treatment Plan or Summary
____ Current Treatment Update
____ Medication Management Information
____ Presence/Participation in Treatment
____ Nursing/Medical Information
____ Toxicological Reports/Drug Screen
____ Educational Information
____ Discharge/Transfer Summary
____ Continuing Care Plan
____ Progress in Treatment/Notes
____ Demographic Information
____ Other _____
____ 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 Mind 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 the release of all medical records including Psychiatric, Alcohol, Drug Abuse, and AIDS records. An individual who wishes to file a complaint against a Licensed Professional Counselor may write to: *Complaints Management and Investigative Section 333 Guadalupe St, Tower 3, Rm 900 Austin, TX 78701. (512) 305-7700.* to request the appropriate form or obtain more information.

Client Name (Printed)

Client Signature (Parent Signature of a Minor) **Date**

Witness Name (Printed)

Witness Signature **Date**

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