Consent & Authorization to Use, Disclose, and Receive Mental Health Information

I, _____, hereby authorize _____
(Name of patient) *(MHI-NB or MHI-LB provider)*
& the Mind Health Institute, Newport Beach (MHI-NB) and/or Mind Health Institute, Laguna Beach (MHI-LB) to release, request, and exchange information and any records obtained in the course of my diagnosis and treatment for the following purposes:

- Increase understanding of my previous history, diagnosis, and treatment
- Coordinate care on an ongoing basis with other providers for continuity of care purposes
- Discuss my care with friends or family that may be important sources of support

Information can be **released to, requested from, or exchanged** with the following:

Name of individual/organization	City, State	Phone number	Fax number

I understand that MHI-NB and MHI-LB are multi-disciplinary clinics and, as such, may share my information with other providers within the practice for the purposes of supervision, consultation, case coordination, clinical coverage, and other collaboration that is focused on providing better and more integrated care on my behalf.

I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing and received by my provider to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

I understand that I have the right to refuse this consent and/or signing of this authorization, and my provider shall not condition my treatment upon this refusal. I understand that I am voluntarily signing this form to release any of my health information to the party or parties designated. ***Unless noted otherwise, this includes all records for any dates of my care.***

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information.

This authorization is effective immediately and shall remain in effect for one year unless explicitly revoked in writing.

Signature: _____ Date: _____
(Patient or legal guardian if the patient is a minor or dependent adult)

Print Name: _____ Relationship to patient: _____

Witness: _____ Date: _____
(MHI-NB or MHI-LB provider)

