Authorization for Disclosure of Protected Health Information

PLEASE COMPLETE THIS FORM IF YOU ARE SEEING A *THERAPIST* OR *COUNSELOR*.

I , _____ , authorize Pleasant Care Behavioral Health Services, Inc.
(Print name)
and / or his designated authorized staff to disclose and provide information including copies of the following protected health information regarding (Check One)

( ) Myself

( ) My minor child over whom I am parent or guardian _____
Name of minor child

( ) My minor child of whom I am the Managing Conservator _____
Name of minor child

( ) Other party of whom I have legal guardianship. (Copy of Court Documents Required). _____
Name of other party

to the following party:

☐ Therapist or Counselor: _____

☐ Other: _____

Protected medical information I am authorizing for disclosure is: (CHECK ALL THAT APPLY).

____Psychiatric Evaluation ____ Progress Notes ____ Medication Records ____ Billing Records

____Treatment Plans or Summaries ____Hospital Records Created by Pleasant Care Behavioral Health Services ____Mental Health Records ____Substance Abuse Records ___ Lab Tests / Study Results ___ Other (Specify)_____

Purpose of Disclosure: ( ) Request of authorized individual patient

( ) Continuation of care by another clinician

( ) In support of application for insurance

( ) Security Investigation for employment.

( ) Insurance review of my claim for services

( ) For review in a legal matter

( ) To assist in educational and / or employment accommodations

This authorization will be in force and effect until revoked in writing by me via Certified Mail Pleasant Care Behavioral Health Services, Inc, 905 medical Centre drive, Arlington, Tx 76012. Pleasant Care Behavioral Health Services, Inc.
I understand that a revocation is not effective to the extent that my provider has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient who may not be bound to the same confidentiality standards as my provider, and, therefore, such disclosed information may no longer be protected by federal or state law. I hold Pleasant Care Behavioral Health Services, Inc. harmless for any adverse consequence derived directly or indirectly from his authorized release of protected health information.

_____ _____
Signature of Patient or Authorized Individual Date

_____ (Print Name)