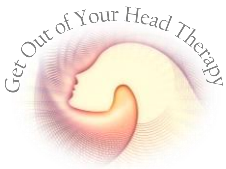

Get Out of Your Head Therapy

Psychotherapy & Counseling Service for Children, Adolescents and Adults
824 W. 10th Street, Suite 200, Austin, TX 78701
3000 Joe Dimaggio Blvd, Suite 60, Round Rock, TX 78665
7111 Bosque Blvd, Suite 102, Waco, TX 76710
O: 512.686.6012 • F: 512.842.7227 • www.getoutofyourheadtherapy.com

MINOR AUTHORIZATION TO RELEASE/RECEIVE PERSONAL HEALTH INFORMATION*

MINOR PATIENT'S NAME: ________________________________ BIRTH DATE: _______________________

I, (Parent/Guardian name) ____ hereby give my consent to

Get Out of Your Head Therapy to release and receive my child's personal health information with the following

practitioners or people regarding the following type of information (check below):

☐mental health ☐medical history ☐family history ☐other:_____________________

Practitioners or people with whom information may be exchanged:

Psychiatrist: ____________________________
Phone: ________________________________
Fax: __________________________________

Other: ________________________________
Relationship to Patient: ___________________
Phone: _______________________________
Fax: _________________________________

Physician: _____________________________
Phone: ________________________________
Fax: __________________________________

Other: ________________________________
Relationship to Patient: ___________________
Phone: _______________________________
Fax: _________________________________

Prior Therapist: _________________________
Phone: ________________________________
Fax: __________________________________

for the purpose(s) of ("Consultation" if left blank):

____

I understand that this authorization is valid for 1 year after the last date of service unless otherwise indicated here: ________________ . I understand that I may, via written request, withdraw my consent at any time, and that I have a right to receive a copy of this authorization form. I also understand that the information being disclosed pursuant to this authorization to individuals outside Get Out of Your Head Therapy may be subject to re-disclosure by the recipient, and may no longer be protected by this privacy rule.

_________________________________ ________________________________ ____________
Name of Parent/Guardian Giving Consent Signature Date

*Compliant with the Health Insurance Portability and Accountability Act (HIPAA)