ADULT AUTHORIZATION TO RELEASE/RECEIVE PERSONAL HEALTH INFORMATION*

Patient Name: _____ Patient Date of Birth: _____

I hereby give my consent to Get Out of Your Head Therapy to release and receive personal health information with the following professionals, people, and/or entities regarding the following type of information (check below):

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

Individuals and/or entities with whom information may be exchanged: **Primary Care Physician Required**

Primary Care Physician: _____
Phone: _____
Fax: _____

Psychiatrist: _____
Phone: _____
Fax: _____

Prior Therapist: _____
Phone: _____
Fax: _____

Lawyer: _____
Phone: _____
Fax: _____

Other: _____
Relationship to Patient: _____
Phone: _____
Fax: _____

Other: _____
Relationship to Patient: _____
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 of 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.

_____ _____
Signature of Patient **Date**

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