A Peaceful Mind® Counseling Group

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I _____, Date of Birth _____ authorize
(Patient Name)

____**A Peaceful Mind Counseling Group**_____ to disclose/obtain information from/with:

_____

_____.
(Name of Organization/person MAKING disclosure including address and phone number)

The following information (nature of information): _____

The purpose of the disclosure authorized herein is to: _____
(Purpose of disclosure as specific as possible)

I understand that my records are protected under the Health Insurance Portability and Accountability Act of 1994 (HIPAA) and educational records under Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) none of which can be disclosed without my written consent unless otherwise provided for by the regulations. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and that A Peaceful Mind Counseling Group will not base my services, payment or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and is no longer protected by federal confidentiality laws or A Peaceful Mind Counseling Group. I understand that A Peaceful Mind Counseling Group will only release the minimum amount of information necessary to fulfill a request. I understand that in the event that I request to revoke a prior authorization, it is my responsibility to notify the agency in writing and sign this revocation. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it. Consents automatically expire **one year from the date signed below.**

_____	_____	_____
Client Name	Signature	Date

☐ Check here if minor with no signature

_____	_____	_____
Parent/Guardian Name	Signature	Date

Revocation

_____	_____
Print name of person requesting revocation	Signature

_____	_____ **am / pm**	_____
Date of revocation	Time of revocation	Staff Member/Witness