Consent for Release of Protected Health Information

_____ **Last 4 of SSN No.** _____ **DOB** _____

(NAME OF PATIENT)

Authorize: Breakthrough Mental Healthcare LLC **to release to:**

(Name of Person or Facility Releasing Information) **(Name of Person or Facility Receiving Information)**

17304 Preston Rd, Suite 800 - Dallas, TX 75252

(Address of Person or Facility Releasing Information) **(Address of Person or Facility Receiving Information)**

The disclosure shall be limited to the following specific information (*Nature and amount of information to be disclosed, as limited as possible to accomplish the stated purpose or intended use.*) (**Check all the apply**.)

_____ Diagnosis	_____ Results of Psychological and Vocational Tests	_____ Summary of Psychological and Psychiatric History
_____ Legal Status	_____ Medical Information, including results of medical tests	_____ Educational Assessment and Behavioral Reports
_____ Other: _____		

Treatment dates to be included in disclosure: _____ to present

Method by which information is to be released: ___Mail ___Fax ___Verbal Exchange ___Other: _____

Information is being released for the following purpose: _____

Date, Event, or Condition when Consent Expires: _____

In the event no date, event, or condition is specified for expiration, this consent expires 15 months from the date of signing.

I understand that my mental health records are protected under state law and federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, and cannot be disclosed without my written consent unless otherwise provided for by regulations. I also understand that treatment services are NOT contingent upon or influenced by my decision to permit the information release. I also understand that I may revoke this consent in writing at any time. I freely and voluntarily give this consent.

I also understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law.

THE INFORMATION I AUTHORIZE FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

Print Name of Patient: _____ Patient's Signature:_____

Patient's Date of Birth: ____/____/_____ Date: ____/____/_____

If Patient is a Minor Child, please complete and sign below.

Print Name of Minor Child Patient: _____ Minor Child's Date of Birth: ____/____/_____

Print Name of Parent/Guardian/Managing Conservator: _____

Signature: _____ Date: ____/____/_____

Parent/Guardian/Managing Conservator