Mindgate Behavioral Specialists
803 Taylor Avenue
High Point, NC 27260
336-689-3444 (O) 336-886-1421 (F)

Consent for the Release of Confidential Information

I._____authorize
(Name of Patient or Guardian)
_____ (Individual/Entity) to disclose to

_____ (Individual/Entity) the following

Information about_____ (Client) DOB_____

_____ Discharge Summary
_____ Psychological Assessment
_____ Consultation Reports
_____ Education History and progress / Cumulative Folder
_____ Progress Notes
_____ Other_____

Exchange of Information by: _____ Telephone _____Correspondence

Information is to be two-way_____ Yes _____No

For the purpose of:

_____To continue Evaluation or treatment ____ To coordinate services ____ Assessment

____ To ensure follow through with wellness exam _____ Facilitate referral

Other Purpose (specify) _____

I, the undersigned, understand that I may revoke (revocation) this consent at any time except to the extent that action has been taken in reliance on it.

I hereby request and authorize the above named agency, organization, or individual, which possesses information relative to the person named above to release/exchange information to the agency, organization or individual named. I understand that the information to be released/exchanged may include information regarding drug/alcohol abuse, sickle cell anemia, tuberculosis, psychological or psychiatric impairments, and/or HIV/AIDS information. If authorization is required to release HIV/AIDS information, please specify that such information is being released. HIV/AIDS information or related conditions are only disclosed in accordance with the communicable disease laws (GS 130A-143)

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42CFRPart2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42CFRPART2.

This consent ends _____or one year from the date I sign it, or other periods as provided by law. (A photocopy/fax is valid as original signature)

Patient's Signature: _____ Date: _____

Signature of Guardian: _____Date: _____

Witness: _____ Date: _____