Name:	**Acct. No:**
Age:	**DOB:**
Phone:	**PC:**
Date:	**Clinician:**

Mental Health Consent to Communicate Patient's 18 years and Older

South Lake Pediatrics
952-401-8300
www.southlakepediatrics.com

Authorization for Release and Receipt of Medical and Other Information

FOR INTERNAL USE ONLY

(A photocopy of the original is acceptable)

Between: South Lake Pediatrics **And:** **Parent(s)/Guardian(s)**

Name:_____

Relationship to Patient:_____

Name:_____

Relationship to Patient:_____

Patient Information to be Released and/or Received by the Parties listed above

Please check all boxes that apply

MENTAL HEALTH

- ☐ Schedule or inquire about Mental Health Appointments
- ☐ Request/Pickup Mental Health Medications
- ☐ Verbal Communication about my Mental Health
- ☐ Other:_____

CHEMICAL USE

- ☐ Verbal Communications about my Chemical Use
- ☐ Other:_____

☐ Check this box **ONLY** if you **do not want any** information exchanged.

Authorization and Revocation

I understand that my records are protected under State and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided by law. I also understand that I may revoke this consent at any time in writing, and that in any event this consent expires automatically 365 days after signing or at termination of services. I understand that any information used by South Lake Pediatrics is limited to staff whose work assignments reasonably require access to my data within the purposes specified in the services provided. Information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

Date: _____ Signature of Patient: _____

Preferred Phone:_____ Ok to leave message ☐ Y ☐ N