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

# Mental Health Consent to Communicate

South Lake Pediatrics
Infant, Child & Adolescent Care
www.southlakepediatrics.com
952-401-8300

Authorization for Release and Receipt of Medical and Other Information
**(A photocopy of the original is acceptable)**

**Between:** South Lake Pediatrics **And:** Name:
Agency:
Address:

Phone:
Fax:

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

**Please check all boxes that apply**

**MENTAL HEALTH**

- ☐ Diagnostic/Intake Evaluation
- ☐ Progress Notes/Treatment Summary
- ☐ Psychological Testing
- ☐ Verbal Communication
- ☐ Other: _____

**CHEMICAL DEPENDENCY**

- ☐ Chemical Dependency Evaluation
- ☐ Chemical Dependency Treatment
- ☐ Verbal Communication
- ☐ Other: _____

**NOTE: For Chemical Dependency, only the patient (including minors) 12 years and older can sign for release of records.**

**Reason for Release or Receipt of Information**

**The information is being received/released for the purpose of:**

- ☐ Assessment, treatment planning and consultation in my/my child's medical care
- ☐ Coordination of my/my child's treatment services
- ☐ Other(specify): _____

**Authorization and Revocation**

I understand that my/my child's 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: _____

Date: _____ Signature of Parent/Legal Guardian: _____

Primary Contact: _____ Relationship to Patient:_____

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