Mindful Therapy Practice
Melissa Barsotti, LCSW # 64017
melissa@mindfultherapypractice.com
www.mindfultherapypractice.com

6994 El Camino Real, Ste 205-G
Carlsbad, CA 92009
T: (626) 893-0480

CONSENT FOR RELEASE OF INFORMATION

I,_____[Name of Patient/Client], whose Date of Birth is_____,

authorize MINDFUL THERAPY PRACTICE treating therapist Melissa Barsotti, LCSW to disclose

to and/or obtain information from:

Name of Agency/Organization/Provider:

_____

Address:

_____

Contact Information/Phone and email:

_____

Attention to:

_____

_____-

the following information:

Description of Information to be Disclosed

(*Patient/Client should initial each item to be disclosed*)

Assessment
_____X Diagnosis
_____X Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information

_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____X_Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_ This clinician previously worked at said group practice and would like to retrieve process note folder left behind, in an effort to ensure continuity of care.
_____Other_____

Purpose

This information may be used or disclosed in connection with mental health treatment, payment, or healthcareoperations.

If the purpose is other than as specified above, please specify:

_____

_____Check here if patient/client refuses to sign authorization

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Revocation and Expiration

I understand that I have the right to cancel this consent for release of information at any time, except when my therapist has already taken action on it. If I wish to cancel this consent, I need to ask my therapist for instructions. Otherwise, this consent will end one year from the date of my signature.

Conditions

I further understand that MINDFUL THERAPY PRACTICE will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected bythe HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Informed risks to privacy and limitations on confidentiality

I have been informed of the risks to privacy and limitations on confidentiality of the use of facsimile machines and electronic means of information transfer, and I accept these.

I have had the provision of this form explained to me and believe that I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for thisindividual (power of attorney, healthcare surrogate, etc.).

I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed, competent, and willing consent.

_____

Signature of Staff Witness Date