Authorization to Disclose Personal Health Information

I, _____ (DOB:)

authorize **Healthy Lifestyles PLLC** to disclose and/or obtain information from:

Name Address Phone Number

_____

_____

_____

_____

- This includes written and verbal transfer of history, as well as mental health and treatment information for the purposes of consultation and coordination with relevant professionals.
- The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.
- I,_____,understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Nimisha Patel LCSW, RD/LD,CEDS at 614-B S Watters Rd Suite 180, Allen TX75013. I further understand that a revocation of the authorization is not effective to the extent that action has already been taken in reliance on the authorization.
- Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated: _____.
- Healthy Lifestyles PLLC reserves the right to disclose information as permitted by this authorization in any manner that is deemed to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.
- I will be given a copy of this authorization for my records.
- I give permission for the following information will be disclosed(please initial):
  Mental health_____ Medical Health_____ Substance Abuse_____

_____

Signature of Patient and/or Parent, Guardian or Personal Representative Date

_____

Signature of Staff Witness Date

__ I have reviewed this authorization and choose not to sign it at this time. (Date/Initial:)