Authorization to Disclose Personal Health Information

I, ____ (DOB:)
authorize **Healthy Lifestyles PLLC** to disclose and/or obtain information from:

Name	Address	Phone Number
Healthy Lifestyles PLLC	550 S Watters Road, Suite 136, Allen, TX 75013	469- 854 -1656

- 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 exchange 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 550 S Watters Rd, Suite 136, Allen, TX 75013. I further understand that once I revoke this authorization, it will not apply in situations where communications with the above parties have already occurred.
- 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 to 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:)