CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Please note! No information will be sent to any party except to the client and/or parent or legal guardian as indicated without the explicit permission.

Patient Name: ____ Date of Birth: _________________________

M&M is networked with various professionals who provide supplemental services. By checking the boxes below, you are giving permission for staff members of Mind and Motion, LLC (M&M), to review information in order to expedite time in joint assessment practices and improve therapeutic efficiency.

I hereby authorize Mind and Motion, LLC

☐ **To release information to** ☐ **To obtain information from** ☐ **To communicate with**

I recognize there are additional organizations, doctors, schools, etc. that would benefit from having specific information provided to/from M&M. Therefore, I hereby authorize Mind and Motion, LLC to send/receive information to the following parties:

Name____ Phone:____
Email: ____ Fax: ____
Street:____ City:__________________ State:____ Zip:___________
Please send the following information (check appropriate box):
☐ Psychological/Allied Health Report ☐ Progress Report ☐ Treatment Summary

Name____ Phone:____
Email: ____ Fax: ____
Street:____ City:__________________ State:____ Zip:___________
Please send the following information (check appropriate box):
☐ Psychological/Allied Health Report ☐ Progress Report ☐ Treatment Summary

Name____ Phone:____
Email: ____ Fax: ____
Street:____ City:__________________ State:____ Zip:___________
Please send the following information (check appropriate box):
☐ Psychological/Allied Health Report ☐ Progress Report ☐ Treatment Summary

After giving due consideration to the extent of this release, I authorize Mind and Motion, LLC to furnish information, including photo static copies of my psychological records concerning my evaluation or treatment, to the above individual(s), organization(s) or to its agent(s), and I further agree to indemnify and hold harmless Mind and Motion, LLC from all liability that may arise from the release of the information herein requested. Any information released in response to this authorization should not be re-released to any other person(s) unless I so specifically authorize. I understand that the records released may contain alcohol and drug treatment information, medical information or psychiatric and psychological information.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it.

____ ____________________________________
Patient/Client Name (Print) Date

____ ____________________________________
Signature (Guardian Signature if Patient is under 18) Date

Mind and Motion Centers of GA ● 5050 Research Ct. #800, Suwanee, GA 30024 ● 678-749-7600 ● www.mindmotioncenters.com
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