mindful reflections
counseling center PLLC

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Authorization to Obtain, Release, and Exchange Clinical Information

Completing and signing this form will allow Mindful Reflections Counseling Center, PLLC to obtain, release, and exchange privileged, confidential, and protected information from your clinical record(s) to and/or from the person or entity you designate below.

Client's Printed Name: _____ Date of Birth: _____

My signature below authorizes Mindful Reflections Counseling Center, PLLC to obtain, release, and exchange clinical information to and/or from:

Name: _____
Address: _____
_____
_____
Telephone: _____
Fax: _____
Email: _____

I want Mindful Reflections Counseling Center, PLLC to obtain, release, and/or exchange the following clinical information (as indicated by checkmarks below) contained within my client/treatment/office records:

- ☐ Appointment dates
- ☐ Clinical interview information
- ☐ Progress/Therapy/Case notes
- ☐ Psychological assessment/test results
- ☐ Other: _____
- ☐ Psychological testing/assessment raw data (e.g., protocols, transcripts, worksheets, etc.)
- ☐ Any written opinions regarding the referral Question addressed in a psychological evaluation
- ☐ treatment planning / recommendations

This authorization will remain in effect until _____ or for 12 months from the date of signing, whichever is sooner.

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to Mindful Reflections Counseling Center's office address. I further understand that my revocation will not be effective to the extent that Mindful Reflections Counseling Center, PLLC has taken action in reliance upon this signed authorization.

_____ _____
Patient or Guardian's Signature Date

_____ _____
Witness Signature Date