The Illuminated Mind, PLLC

4121 Okemos Rd, Ste 15

Okemos, MI 48864

Authorization to Release Protected Healthcare Information

Patient's Full Name: _____ DOB:_____

I request and authorize The Illuminated Mind, PLLC to disclose and/or exchange mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to therapist's diagnosis, of the client listed above to:

- Institution/Individual Name: _____

  Address: _____

  City: _____ State: _____ Zip code: _____

  Phone: _____ Fax: _____

The purpose of disclosure is for:

☐ Treatment Coordination ☐ Treatment Planning

☐ Diagnostic Refinement ☐ Other: _____

Such disclosures shall be limited to the following specific types of information:
(Check all that apply)

☐ Demographic/Personal information ☐ Treatment Summary

☐ Mental Health diagnosis(es) ☐ Full Treatment Record

☐ Dates of Treatment ☐ Other: _____

This authorization shall remain valid for **one year** or until the date specified here: _____ .
I understand that I do not have to sign a release of information. I also understand that I may revoke or modify this authorization at any time and that all changes must be made in writing.

Signature of Client _____ Date _____
(or legal guardian)