Health and Mind, LLC
1555 Post Rd E suite 201A
Westport, CT 06880
Tel: 203-955-1822
Fax: 203-635-8159

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name: _____ DOB: _____ Date: _____

I, the undersigned, authorize Dr. Tasneem Khan/ Health and Mind, LLC to:

___ Disclose information to **___ Obtain information from**

Name of person/organization: _____

Address: _____ City: _____ State: ____ Zip: _____

Tel: ( ) _____ **Fax: ( ) _____**

I understand that this authorization is voluntary and may include Psychiatric, Medical, Substance abuse and/ or HIV/AIDS treatment information unless otherwise specified:

Purpose of Release:

___ Evaluation/Treatment **____ Other _____**

Information to be released/obtained:

__Psychiatric evaluation
__ Psychological evaluation/testing
__ Psychosocial history/assessment
__ Discharge Summary
__ Medical history/physical exam
__ Medication Records
__ Diagnostic Reports
__ Other _____

Dates of treatment to be covered by this release:

__ All prior episodes of care **__ Following dates _____**

This authorization if not canceled will expire in 12 months from today's date. I understand that refusal to sign this authorization will in no way affect my right to obtain treatment, except when disclosure of such communication and records is necessary for treatment. I also understand that I may revoke this authorization at any time by signing the cancellation/revocation below, except to the extent that action has been taken in reliance on it. I further understand that the confidentiality of Psychiatric, Substance abuse and HIV/AIDS records are under State and Federal Laws.

Name: _____ Signature: _____ Date: _____

I am requesting Cancellation/Revocation of this release:

Name: _____ Signature: _____ Date: _____