Happy Minds Psychiatry PLLC
800 Bonaventure Way STE 104, Sugar Land, TX 77479 Ph: 832-786-0234 Fax: 979-730-3125

CONSENT TO RELEASE INFORMATION

PSYCHIATRIC / MEDICAL and/or ALCOHOL / DRUG ABUSE RECORDS

Patient's Name: _____ **BIRTH DATE:** _____/_____/____

I, _____hereby authorize

Happy Minds Psychiatry PLLC /_____
800 Bonaventure Way STE 104, Sugar Land, TX 77479 Ph: 832-786-0234 Fax: 979-730-3125

to have bilateral exchange of information that is contained in my medical records with:

NAME:_____**PHONE:**_____

ADDRESS:_____**FAX:** _____

INFORMATION TO BE RELEASED:

____ Psychiatric/medical/alcohol/drug abuse evaluation.
____ Psychiatric/medical/alcohol/drug abuse discharge summary

____ Progress notes.
____ Psychotherapy notes
____ Lab studies
____Other:

____Psychological testing
____Educational testing
____ Medical tests/studies
____Other:

Purpose Of disclosure: Continuing care/Treatment, and/or _____

I understand that I may revoke this consent at any time and that any notice to revoke consent must be in writing.
If not previously revoked, this consent to release mental health information will expire 180 days after.

_____ _____
Signature **Date**

_____
Relationship to patient (self or guardian/Parent)