MIND24-7
An open door to mental health care, around the clock.

MIND 24-7 Consent for Release of Confidential Information

Please complete the following form in its entirety to authorize MIND 24-7 to send and/or receive confidential medical information.

Patient Name *

First Name Last Name

Patient Date of Birth: *

Month Day Year

I authorize MIND 24-7 to:

- ☐ SEND
- ☐ RECEIVE

The following information:

- ☐ Confirmation of presence in treatment
- ☐ Medical history and evaluation(s)
- ☐ Psychiatric History and Assessment
- ☐ Psychological Assessment
- ☐ Biopsychosocial Assessment
- ☐ Laboratory Test Results
- ☐ Progress in treatment
- ☐ Treatment plans
- ☐ Discharge Summary and Recommendations
- ☐

Through the following methods:

- ☐ Electronic
- ☐ Oral
- ☐ Written

To the following Person or Agency:

Phone number:

Please enter a valid phone number.

Fax number:

Please enter a valid phone number.

Email:

example@example.com

Relationship to Patient:

The above information will be used for the following purposes:

- ☐ Continuity of treatment – Patient History – Case Management Services
- ☐ Emergency Contact – General Updates
- ☐ Court Services – Legal Purposes – Probation – Disability claiming – Unemployment Claiming – Employment Continuity
- ☐

My records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS), and/or related conditions. *

☐ I UNDERSTAND

I may revoke this authorization at any time upon written notice to Mind 24-7. I acknowledge that such revocation will not be effective if Mind 24-7 has already acted in reliance upon this authorization. *

☐ I UNDERSTAND

This authorization is valid (if not previously revoked) this consent will terminate upon 90 days from the date of signature of this form, or the following event/condition: (PLEASE EXPLAIN IN OTHER BELOW), or the completion of treatment, or at the time of the final insurance billing, as the case may be, whichever is later. *

☐ I UNDERSTAND

☐ _____

PROHIBITION ON RE-DISCLOSURE: This information has been disclosed from records protected by Federal Confidentiality Rules (42 CFR part 2). The Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. *

☐ I UNDERSTAND

Signature

_____

Name

First Name _____ Last Name _____

ONCE COMPLETE, PLEASE EMAIL THIS FORM TO CUSTOMEREXPERIENCE@MIND24-7.COM.

If we have any questions about your submission, we will reach out to the contact information provided above. If you have any questions, please contact us by calling **844-MIND247 (844-646-3247)** or by emailing us at **customerexperience@mind24-7.com**.