Comfort Minds & Above Behavioral Health
9500 Ray White Rd Ste 200
Fort Worth, Texas, US - 76244

Authorization For Release of Confidential Information (Therapist)

I, (Print First and Last Name and Date of Birth), * _____

authorize Comfort Minds & Above LLC. and Dr. Stewart Keller/Shuntak Jerideau PMHNP to disclose protected health information to:

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Name of Entity or Individual: * _____

Address of Entity or Individual: * _____

Phone of Entity or Individual: * _____

Fax of Entity or Individual * _____

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The release of this information is concerning all dates of my treatment unless specified here: (If you want to restrict the dates of the treatment information shared, please type the specific date range here) _____

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The release of information is limited to the following information (select all that apply): *

- ☐ All Information within the patient record
- ☐ Admission and Discharge Summaries
- ☐ Consults
- ☐ Test Results
- ☐ Progress Notes
- ☐ Other

If you selected "other" please specify here _____

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SPECIAL LIMITATIONS: This Authorizations EXCLUDES (check all that apply):

- ☐ HIV/AIDS test results (if part of the specified record)
- ☐ Substance abuse treatment records
- ☐ Substance abuse treatment records

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This information is to be used for the purpose of collaboration, continuity and/or transition of care.

I understand that I can cancel this authorization at any time by sending a letter or email/electronic message to the Privacy Officer of Comfort Minds & Above LLC.. If I do this, it will prevent any disclosures of my information after the date it is received but cannot change the fact that some information may have been disclosed before that date.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or my eligibility for benefits.

I understand that I may inspect and obtain a copy of the health information described in this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed and is no longer protected by those regulations.

I agree that everything in this form that was not clear to me has been explained, that I have been able to ask questions about it, that my questions have all been answered in a manner satisfactory to me and in language that I understand, and I believe I now understand all of it.

This authorization is valid as of the date it is signed and continues in effect for 1 year. This authorization can be formally revoked by written letter/email/electronic message, or verbal communication by the patient. By signing this authorization, I acknowledge that I have received a copy of this form.

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PATIENT SIGNATURE * _____

Printed Name: * _____

Date: * _____