SHAWNA S. BRENT, MD

BOARD CERTIFIED CHILD, ADOLESCENT & ADULT PSYCHIATRIST

CONSENT FORM
For Disclosure of Mental Health Treatment Information

_____ (Patient name) whose Date of Birth is _____
authorize Shawna S. Brent, MD to disclose to **and** obtain from:

Name of Provider/Facility_____
Address: _____
Office Phone Number: _____ Office Fax Number: _____
The following information:

Description of Information to be Disclosed:
_____ Medication Management Information
_____ Diagnosis
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Continuing Care Plan
_____ Progress in Treatment

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Dr. Brent. Unless sooner revoked; this authorization expires one year from signature.

I further understand that Dr. Brent will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may complicate my progress

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

_____
Signature of Patient/Client Date

_____
Signature of Parent, Guardian or Personal Representative Date
If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

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