# Consent to Share/Receive Information

*We believe every person deserves to feel, heal, and evolve*

I, ________________________________________[Name of Client], Date of Birth ______________, authorize Head & Heart Therapeutic Solutions to share with or receive from information about me in connection with mental health treatment, substance use disorder treatment, payment, or healthcare treatment: [*list the specific names of healthcare providers, insurance plans, family members, or others]*

1. ___________________________________ 2. ___________________________________
3. ___________________________________ 4. ___________________________________
5. ___________________________________ 6. ___________________________________

**Description of Information to be Disclosed (choose ONE)**

- ☐ Share ***all*** my mental and behavioral health and substance use disorder records. This does not include "psychotherapy progress notes".
- ☐ Share **only** the types of records listed below:
  - ☐ Dates of Service
  - ☐ Assessment
  - ☐ Diagnosis
  - ☐ Psychosocial Evaluation
  - ☐ Treatment Plan or Summary
  - ☐ Current Treatment Update
  - ☐ Presence/Participation in Treatment
  - ☐ Educational Information
  - ☐ Discharge/Transfer Summary
  - ☐ Demographic Information
  - ☐ Payments Made
  - ☐ Other________________________

I understand that I have a right to revoke this authorization by completing the "Withdrawal of Consent" section of this form.

**By signing this form, I understand:**

- I am giving consent to share my mental and behavioral health and substance use disorder records with the people or organizations listed above.
- The information I've noted above will be shared to help diagnose, treat, manage, coordinate and/or pay for my health needs.
- This form does not give my consent to share "psychotherapy progress notes".
- I have read this form. All of my questions about this form have been answered.
- I can revoke my consent at any time.
- This signature is good for 1 year from the date signed. Or I can choose an earlier date or have it end after the event or condition listed below.
  Date, event, or condition: ______________________________________________

State your relationship to the person giving consent and then sign and date below:

- ☐ Self
- ☐ Parent (Print Name) ______________________________________________
- ☐ Guardian (Print Name) ______________________________________________
- ☐ Authorized Representative (Print Name) ________________________________

Signature: ________________________________________ Date: _______________

**Withdrawal of Consent:**

☐ I no longer want to share my records with those listed above.

I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent and then sign and date below:

☐ Self
☐ Parent (Print Name) ____________________________________________
☐ Guardian (Print Name) ____________________________________________
☐ Authorized Representative (Print Name) ______________________________

Signature: ______________________________________ Date: __________