Center for Integrative Psychiatry
580 S Denton Tap Rd, Suite # 280
Coppell, TX - 75019-4005

Consent to Release of Information_PRINTABLE

I hereby authorize the Center for Integrative Psychiatry to transfer, release, or obtain information with the individual(s) named below.

Name of Provider or the facility: *

Mailing address: *

Phone number: *

Fax number: *

I would like to make an exception of the following topics or areas of discussion. I do not give consent for information about the following to be discussed. *

☐ None

Patient Rights & Acknowledgment:
I understand that I may revoke this authorization at any time by submitting a written request, except to the extent that information has already been released.
I understand that signing this form is voluntary, and that my treatment, payment, or eligibility for benefits will not be affected if I choose not to sign.
I understand that once my information is released, it may no longer be protected under HIPAA if re-disclosed by the recipient.
I acknowledge that certain disclosures may be required by law, including but not limited to: court orders, subpoenas, law enforcement investigations, mandatory reporting of abuse or neglect, or when otherwise legally compelled.
I also understand that disclosures may occur to protect the safety of the patient or others, including situations involving risk of harm to self, threats to others, or public safety concerns.

Patient Full Name *

Patient Date of Birth *

Center for Integrative Psychiatry
580 S Denton Tap Rd, Suite # 280
Coppell, TX - 75019-4005

Signer Full Name * ☐ Patient ☐ Authorized Representative

Authorized Representative Full Name: *

Relationship of the signer to Patient * ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

Patient Signature or Legally Authorized Representative *

Date Signed: *