Authorization for Release of Information

I, _____, authorize Mending Hearts Counseling
(Print Name)

(MHC) Staff to release protected information from my clinical record to the person / agency designated below:

	Designated Recipient / Agency
MHC Staff	
Name, Title	Name, Title
Mending Hearts Counseilng	
Organization	Organization
8620 N. New Braunfels Ave. Suite 538	
Street Address	Street Address
San Antonio, Texas, 78217	
City, State, Zip	City, State, Zip
210-895-4309 / 210-899-1415	
Phone Fax Number	Phone Fax Number

I am requesting a release of the following specific information - **All relevant clinical data**

for the following specific reasons: **Continuity of care**

[X] I agree to release relevant information about my mental health _____
Initials

THIS AUTHORIZATION AUTOMATICALLY EXPIRES ONE YEAR FROM DATE OF SIGNATURE

Special Instructions/Alternative Expiration Date: _____

Acknowledgement: *I understand that upon release and disclosure of the protected medical records and/or information, the records and information may be subject to re-disclosure by the Recipient and may no longer be protected by state or federal privacy regulations.*

I further understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Mending Hearts Counseling address. No emails will be accepted. However, my revocation will not be effective to the extent that the Mending Hearts Counseling Staff has already taken action in reliance on the authorization.

Print Name of Client/Former Client

Phone

Signature of Client/Former Client

Date

Street Address

City, State, Zip