The Rested Mind, LLC 62 Derby Street Suite 11 Hingham MA 02043
781-374-4100 781-749-0809 (fax)

Consent for Release of Information

I, ____
(Client Name) (Date of Birth) (SS#)

request and authorize The Rested Mind, LLC to ☐ Exchange with ☐ Receive from ☐ Provide to/with

____
(Name and Address of Agency or Person to Provide or Receive Information)

information (in written and/or oral form) regarding:

☐ Initial Evaluation and Recommendations ☐ Medical History

☐ Treatment Summary ☐ Diagnosis and Assessment

☐ Psychological Evaluation ☐ Physician Notification

☐ Social History ☐ Hospital Discharge Summary

☐ Progress Notes ☐ Summary of Treatment Participation/Progress ☐ Appointment Times/Attendance

☐ Coordination of Care ☐ Financial/Insurance Information

This information is for the purpose of:

☐ Assisting with the client's evaluation and treatment

☐ Coordinating services between The Rested Mind, LLC and agency or person named above

☐ Transferring information regarding previous treatment

☐ ______________________________

I understand that this consent will automatically expire in 90 days from the date signed or if consent is retracted In writing.

I authorize you to send/receive copies of these records or reports to/from The Rested Mind, LLC at the address shown on this form. Copies are $0.25 per page.
I understand that my clinical record may contain psychiatric, mental health, developmental disabilities, alcohol and/or drug abuse information and/or Acquired Immune Deficiency Syndrome (AIDS) and/or HIV test results and information.
I authorize the release of the information itemized above solely for the purpose itemized on this consent form. Only such information and/or records believed necessary for the purpose expressed above shall be released and disclosed. I may inspect and copy the information to be disclosed.
I understand that I have the right to revoke this consent at any time. The revocation must be in writing and received by the person releasing the information. I understand that the revocation will not apply to information that has already been released in response to this authorization.
I understand that information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the information.
I understand that the information received cannot again be given to any other agency or person without my written consent.
I understand that I do not have to sign this authorization and The Rested Mind, LLC may not condition treatment on whether I sign this authorization.

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Client Signature (Parent signs for clients under the age of 18 years old) Date

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