Texas Psychiatry Associates, PA

3417 Spectrum Blvd, Ste 200, Richardson, TX 75082
Phone (972)478-0322 / (817)684-2710
Fax (972)907-1187 Email tpa@innovatedminds.com

Consent to Discuss Medical Information and Protected Health Information

Patient Name: _____

Patient Date of Birth: _____

I authorize Innovated Minds-Texas Psychiatry Associates, P.A. and its staff to discuss my medical information as follows: (Initial below all that apply)

_____ For financial purposes, I allow my parent/guardian(s) access to my diagnosis and treatment information and to discuss my account

_____ I allow my treatment plans (i.e.: medications) to be disclosed to my parent/guardian(s)

_____ I allow my office visits to be accessed by my parent/guardian(s)

_____ I allow my labs to be released to my parent/guardian(s)

_____ With my prior consent, I allow my "confidential information" to be shared with my parent/guardian(s)

I consent to my protected health information being disclosed to the following individuals:

_____ _____
Parent/Guardian (please print) Relationship to Patient

_____ _____
Parent/Guardian (please print) Relationship to Patient

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via phone, fax, and/or in person.

I understand that I may revoke this consent at anytime and must notify Innovated Minds-Texas Psychiatry Associates, in writing, in order to revoke the consent. I fully understand and accept the terms of this consent.

_____ _____
Signature of Patient Date

_____
Patient's Printed Name

REVOKE CONSENT

(Do not sign below unless you are revoking the above consent)

I hereby revoke the above consent effective immediately. I understand that revoking this consent means that my medical information and protected health information will no longer be discussed or disclosed (released) to the above individuals and that a new consent will need to be completed if this changes.

_____ _____
Signature of Patient Date