Texas Psychiatry Associates, PA

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

Consent to Discuss Medical Information and Protected Health Information

Patient Name:_____

Patient Date of Birth: _____

I authorize Texas Psychiatry Assocaites, P.A. and its staff to discuss my medical informaiton as follows: (Initial below all that apply)

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

_____ I allow my treatment plan (i.e.: medication) to be discussed 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 any "confidential information" to be shared with my parent/guardian(s)

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

_____ _____
Parent/Guardian **Relationship**

_____ _____
Parent/Guardian **Relationship**

_____ _____
Parent/Guardian **Relationship**

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 Texas Psychiatry Associates in writing in order to revoke the consent. I fully understand and accept the terms of this consent.

_____ _____
Signature **Date**

_____
Printed Name