



**RELEASE OF INFORMATION**

I hereby authorize:

**IntegrityMind Psychiatry**  
[www.IntegrityMind.com](http://www.IntegrityMind.com)

180 State Street, Suite 225

Southlake TX 76092

Telephone: (682) 253-2783

Fax: (844) 510-3779

Email: Office@IntegrityMind.Hush.com

\_\_\_\_\_  
 Name of Other Party

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City, State, Zip Code

to both release and obtain information from:

\_\_\_\_\_  
 Telephone # / Fax #

For dates of service from: \_\_\_\_\_ to COMPLETION OF TREATMENT.  
 Specific dates or from "start of treatment"

- I release the above cited individuals or facilities of any legal liability that may arise from the release of the information request. I understand that the practice/agency cannot release information obtained from other sources.
- I understand that the individual/institution/agency receiving this information may not release it to any other individual, institution or agency.
- I understand that this release of information can be revoked by me at any time and that the revocation must be signed and dated by me.

I have read this form (or it was read to me) and I understand it. By signing, I am bound by these terms. I certify that the information set forth is complete and correct.

\_\_\_\_\_  
 Patient or Parent/Guardian Signature      Date of Birth of Patient      Today's Date

\_\_\_\_\_  
**Patient's** Printed Name      Relationship to Patient (If signing as a parent/guardian, i.e. mother, father, etc)

**Authorization to Revoke Consent**

I hereby revoke my consent for the release of the above information. I understand that disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, therefore IntegrityMind Psychiatry/Paul Wright MD PLLC is hereby released from any legal responsibility or liability for the disclosure of the information I previously authorized.

\_\_\_\_\_  
 Patient or Parent/Guardian Signature      Date of Birth of Patient      Today's Date

\_\_\_\_\_  
**Patient's** Printed Name      Relationship to Patient  
 (If signing as a parent/guardian, i.e. mother, father, etc)