Healing TMS
TMS Mental Health Clinic

Healing TMS Clinic
5475 East La Palma Avenue, Suite 204
Anaheim, CA 92807
(657) 656-5611 • hello@htmsclinic.com
Monday–Friday, 9:00 AM – 5:00 PM

Permission to Share / Retrieve Protected Health Information

Completion of this form is optional. Fields may be typed before printing for signature.

Patient information

Patient name _____ **Date of birth** _____

Street address _____

City _____ **State / ZIP** _____

Preferred phone _____ **Work phone** _____

I authorize Healing TMS Clinic to share & retrieve information about me with:

Name _____ **Relationship** _____

Phone _____ **Fax** _____

Email _____ **Custom PIN** _____

For communication with non-service providers, please create a custom PIN that your consented contact must use when calling the office.

What we may share with this person

(check all that apply)

- ☐ Scheduling & appointment information
- ☐ Medical & behavioral health information — symptoms, diagnoses, medications, treatment plan
- ☐ Billing & payment information
- ☐ Other (describe): _____

How long should this permission remain valid?

(select one — required)

- ☐ Valid for 1 year from the date signed
- ☐ Valid until 30 days after discharge from care
- ☐ Valid through a specific date: _____

Right to revoke

I have the right to change or revoke this permission in writing at any time, except where Healing TMS Clinic has already made disclosures in trust of this original authorization. I must complete a new form or notify Healing TMS Clinic staff **in writing** to change or revoke the permissions above.

Printed name _____

Signature _____ **Date** _____

You are entitled to a copy of this consent after you sign it. Return the completed and signed form to the clinic via email at hello@htmsclinic.com, by fax, or in person at the address above.