



# MENSA®

## WRITTEN CONSENT & AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

I, \_\_\_\_\_, pursuant to the Texas Health and Safety Code (Sec. 576.005) and any applicable provisions of the Federal Health Insurance Portability and Accountability Act ("HIPAA") and the rules thereunder hereby authorize American Mensa, Ltd. to release and disclose:

\_\_ Results of Psychological Testing (Raw Score and Percentile Ranking)

Relating to examinee, \_\_\_\_\_ (D/O/B: \_\_\_\_\_) to the following organization or agency: \_\_\_\_\_ for the purposes of review as prior evidence.

I request that my scores be sent via (fax, email, or mail) \_\_\_\_\_ to (please list fax number, address, or email address): \_\_\_\_\_.

I understand that I may revoke this consent in writing at any time, and that I have the right to inspect and copy the information to be disclosed.

This consent is valid for 45 days from the below signed date.

I hereby release American Mensa, Ltd. from any and all legal liability that may arise from the release of the information requested.

\_\_\_\_\_  
Printed Name (Legal Guardian or Examinee)

\_\_\_\_\_  
Signature (Legal Guardian or Examinee)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name (Legal Guardian or Examinee)

\_\_\_\_\_  
Signature (Legal Guardian or Examinee)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name (Witness)

\_\_\_\_\_  
Signature (Witness)

\_\_\_\_\_  
Date

Please email completed forms to the Director of Membership at  
MembershipDirector@americanmensa.org.

**NOTICE TO RECEIVING AGENCY/ PERSON:** Under the provisions of the Texas Health and Safety Code, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such a re-disclosure. Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records may be further disclosed without specific authorization of such re-disclosure.