Mindful Mountain Wellness Center, LLC

Authorization for Release of Information

Patient Name: [First, Middle, Last] _____

Patient Date of Birth: [MM/DD/YYYY] _____

Patient Address: [Street, City, State, ZIP] _____

_____

Name of Organization/Individual for Release: _____

Address: _____

Phone Number: _____

Purpose of Disclosure

[ ] Coordination of care [ ] Record Request

Information to be Released

[ ] Mental health treatment records [ ] Substance use treatment records

[ ] Medication list [ ] Lab results – Date range: _____

[ ] Diagnostic information [ ] Other:_____

Dates of Treatment: [Specify range or indicate "All dates"] _____

- I understand that I have the right to revoke this authorization at any time by providing written notice to Mindful Mountain Wellness Center. However, revocation will not affect any actions taken before the receipt of the revocation notice.

This authorization will expire on [_____/ ____ /_____], or upon the following: [Specify event, if applicable]. _____

_____

( ) - I understand that I am not required to sign this authorization and that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my signing this form.

( ) - I acknowledge that I have read and understand this authorization, and that it complies with HIPAA and 42 CFR Part 2 requirements.

Patient Signature: _____ **Print Name**: _____

Date: _____

If unable to sign or under age of 14, Parent or Guardian:

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

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