Mindful Living Group

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Authorization for Use and Disclosure of Protected Health Information for new Medication Management Clients

Patient Name:		**Birth Date:**	
Address:		SSN:	

Information to be disclosed	**Purposes of Use and/or Disclosure**
☐ All Dates of Service ☐ Specified Dates:	☐ To facilitate treatment & medical/psychological need ☐ Other, please specify:
☐ Entire Medical Record ☐ Only Medication Information ☐ Other, Please Specify here:	**I agree to the release of the following information should it be contained in my medical record**
	☐ Acquired Immune Deficiency Syndrome (AIDS) or HIV ☐ Alcohol and/or drug abuse treatment ☐ Behavioral or mental health services

Unless otherwise revoked and specified, this authorization will expire upon written request.

A reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication. This authorization is voluntary. I understand that the above-named health care provider(s) or health plan(s) will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed by law. I understand that I may revoke this authorization at any time by notifying the above-named provider(s) in writing of my revocation. I understand that the revocation will not apply to any information that is already released or used in reliance on this authorization and there may be other legal restrictions on my ability to revoke this authorization. I understand that the revocation will not apply if the authorization was obtained as a condition of obtaining insurance coverage, when the law provides my insurer with the right to contest a claim under my policy or my policy itself. I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under the federal privacy regulations.

I release the above-named provider from all liability and claims whatsoever pertaining to the disclosure of information as contained in the records released pursuant to this authorization.

I have read and agreed to the contents of the PHI Form, and by submitting this form I authorize Mindful Living Group to release and/or exchange my protected health information with my current and previous medical providers.

Patient / Guardian Signature:		If Guardian, relationship to Patient:		**Date:**	