



Authorization for Use/Disclosure of Protected Health Information (PHI)

I hereby request and authorize Mindfull Strategies, LLC to:

(Initial one or more choices below)

____ Obtain copies of my records checked below from:

(Initial)

Name (receiving person/party): _____

Address: _____

Fax No.: _____ Phone No. _____

____ Provide **copies** of my records checked below to:

(Initial)

Name (receiving person/party): _____

Address: _____

Fax No.: _____ Phone No. _____

____ Permit **review** of my records checked below by: _____

(Initial)

____ Permit _____ to be present during my consultation

(Initial)

____ Use/disclose PHI as described: _____

(Initial)

This authorization applies to records of PHI access from the following date or dates of service _____

The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but may include other detailed mental health information, HIV/AIDS information and/or information regarding alcohol or substance abuse

- | | | |
|---|---|--|
| <input type="checkbox"/> Entire Medical Record* | <input type="checkbox"/> Discharge Summary Reports | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Abstract of Record** | <input type="checkbox"/> Doctors Orders | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> Financial Record | <input type="checkbox"/> Electro Cardiogram (ECG/EKG) Reports | <input type="checkbox"/> Physical/Occupational Therapy (PT/OT) Notes |
| <input type="checkbox"/> Pathology Slides/Blocks | <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Radiology Films | <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Speech-Language Pathology Reports |
| <input type="checkbox"/> Ambulance Record | <input type="checkbox"/> Gastro Intestinal (GI) Lab Report | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Autopsy Report | <input type="checkbox"/> History and Physical Report | <input type="checkbox"/> Diagnostic Photos-Specify _____ |
| <input type="checkbox"/> Cardiac Cath Report | <input type="checkbox"/> Laboratory Test Results | <input type="checkbox"/> Other-Specify _____ |
| <input type="checkbox"/> Consent Forms | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Notes-Specify _____ |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Neurodiagnostic Reports | <input type="checkbox"/> Psychological Evaluation |

*Entire Medical Record includes all items NOT in bold print

**An abstract of the record includes the History/Physical Report, Operative, Consultation and Discharge Summary Reports, and diagnostic test results.

Purpose of Use or Disclosure: At the request of the individual (client)
 Other _____

The following information is needed to assist the provider in locating the patient's records:

Client's Full Name: _____ Patients SSN: _____

Maiden/Other Name: _____ Patient's Date of Birth: _____

Client's Phone No. (Home) _____ (Work): _____ (Cell): _____

Address _____

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. I further understand that this Authorization is specific to the information checked above, for the date(s) of services indicated, and for the purpose written above. Mindfull Strategies shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty-exams).

I further understand that this Authorization is valid for a period of 90days from today's date and will expire at that time unless another date is written here _____

Client or Legal Representative's Signature Please Print Client of Legal Representative's Name Today's Date

As Legal Representative, my relationship to the patient is _____ (Any document proving such authority must be attached). The patient is unable to sign because _____

Note: There may be fees for provision of any or all requested information. Under most circumstances, the law permits up to 30 days for record requests to be processed, however records for treatment purposed can be immediately faxed to the patient's healthcare provider when requested.