

Release of Information

WellMind with Dr. Michael D. McGee

Tel: 805 459 8232

Fax: 877 399 5883

6613 B Bay Laurel Place, PO Box 2589, Avila Beach, CA 93424 **Email:** mdm@wellmind.com

Authorization to Release Medical Records and Verbally Share Protected Health Information

Patient Name:
Street Address:
City, State, Zip Code:

DOB:
Phone #:

I authorize Dr. McGee to release all of my Protected Health Information (PHI—to include HIV/AIDS results and drug or alcohol abuse information protected by Federal Regulation 42CFR) and to discuss my treatment with the following provider or other person involved in my care:

Provider/Other Name:
Street Address:
Street Address 2:

Provider/ Other Role:
Provider/Other Phone #:
Provider/Other Email:
Provider/Other Fax #:

City, State, Zip Code:

I further authorize the above provider/other person involved in my care to release all of my Protected Health Information (PHI-to include HIV/AIDS results and drug or alcohol abuse information protected by Federal Regulation 24CFR) to Dr. McGee and to discuss my treatment with Dr. McGee.

I understand that consent is subject to revocation at any time in writing to Dr. McGee, except if medical records or verbal information have already been disclosed. I understand that if health information is disclosed by this authorization, it may no longer be protected under the terms of the privacy rules and the recipient may be able to legally re-disclose the health information to others. I have carefully read and understand the above statements. I hereby release Dr. McGee from all legal responsibility or liability from the disclosure of PHI either in my medical records or verbally. I wish for this authorization to remain in place for the duration of my treatment and beyond until such time as I have revoked this authorization in writing to Dr. McGee.

Date:

X _____



Signature Certificate

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LEGALLY SIGNED USING
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Audit

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