Release of Information

WellMind with Dr. Michael D. McGee (and associates)

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Authorization to Release Medical Records and Verbally Share Protected Health Information

Patient Name:		DOB:	
Street Address:		Phone #:	
City, State, Zip Code:			

I authorize WellMind staff and my WellMind providers 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:		Provider/ Other Role:	
Street Address:		Provider/Other Phone #:	
Street Address 2:		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 my WellMind providers and to discuss my treatment with my WellMind providers.

I understand that consent is subject to revocation at any time in writing to my WellMind providers, 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 my WellMind providers 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 my WellMind providers.

Patient or Guardian Signature ***Print Name***

Date

X

Signature Certificate

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