MINDPATH HEALTH

Authorization For Disclosure of Health Information

I hereby authorize Mindpath Health, it's staff and providers to:
(Please check all that apply)

❑ Disclose information to: ❑ Request information from:

Name _____ Organization/ Medical Group Name _____

Office Address Street _____ City, State, Zip _____

Office Phone Number _____ Office Fax _____

Purpose of Disclosure

The purpose of the disclosure of my health information is:

❑ Care Coordination ❑ Treatment Planning ❑ Legal
❑ Billing/Payment Activity ❑ Personal Use

❑ Other (Specify):

_____

Information to be Disclosed

I authorize the following information to be disclosed:

☐ All of my health information and records, including information about my appointments, prescription medications and billing/payment for my care

OR

☐ Only the following information (specify):

_____

I authorize the disclosure of the following specially protected health information *(check and initial all that apply)*:

☐ Abortion
☐ Alcohol/drug treatment records
☐ Genetic test results
☐ HIV/AIDS test results
☐ Inpatient/residential mental health treatment information
☐ Pregnancy test results
☐ Sexually transmitted or other communicable diseases

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Expiration and Revocation

This Authorization will expire on the date that is five (5) years from the date of my signature below.

I understand that I may revoke this Authorization at any time by notifying Mindpath Health in writing, except to the extent Mindpath Health has already taken action in reliance on this Authorization.

Signature

I have read this form and I understand and agree to its terms. I authorize Mindpath Health to disclose the information identified above.

I understand that Mindpath Health cannot condition my treatment, payment, enrollment or eligibility for benefits on my provision of this Authorization. I understand that information disclosed pursuant to this Authorization, except for alcohol/drug treatment records protected by 42 CFR Part 2, may be subject to redisclosure by the recipient and no longer protected by HIPAA. I understand that I have the right to receive a copy of this Authorization.

_____ _____

Patient Signature Date

_____ _____

Patient Name Patient Date of Birth

_____

Email Address

If you are signing this Authorization For Disclosure of Health Information as a parent, guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

❑ Parent ❑ Conservator ❑ Power of Attorney for Health Care
❑ Guardian ❑ Health Care Surrogate ❑ Executor / Administrator

_____ _____

Signature Date

_____

Name