RELEASE OF MEDICAL INFORMATION

Medical and Mental Health Records Release and Specific Authorization for Use

Patient Name: ___________________________________ Date of Birth: _____________ Phone: ___________________

Address: ____

______I hereby **Request** that the following heath/mental health information be **delivered to** ___Dr. Gioia Guerrieri__ at Well-Minded, LLC **from** the following individual(s) /organizations(s):

Name: ____ Phone: __________________FAX ______________________

Address: ____

Name: ____ Phone: __________________FAX ______________________

Address: ____

Name: ____ Phone: __________________FAX ______________________

Address: ____

______ I hereby authorize the **delivery** of of my health/mental health information **from** Well-Minded, LLC to the following individual(s)/provider(s)/organizations(s):

Name: ____ Phone: __________________FAX ______________________

Address: ____

Name: ____ Phone: __________________FAX ______________________

Address: ____

This release of my medical information is to request/deliver the following services (*please circle all that apply*):

__lab results __ECG __X-rays __ Imaging (CT/MRI) __Medication History __Discharge Summary __Admission notes __Treatment Plans __Physical Exam __Treatment notes __Other: ____________________________________

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. By Signing below, I also acknowledge that I have read and received my "Notice of Health Information Practices".

Name (print) _________________________________ Signature ______________________________ Date___________

This authorization has no expiration date *unless noted here*: ___________________