LIFE healing center

mental healthcare individualized to fit your needs…

Phone: 678-344-8268
Fax: 888-627-6444

Authorization for Disclosure of Protected Health Information

I, _____, authorize the disclosure of my protected health information, or the information for as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

Patient Name: _____ Date of Birth: _____

I authorize the following person(s) or organization(s) to **disclose** my protected health information (as specified below):

Life Healing Center, PC.
500 Plantation Park Drive
Loganville, GA 30052

I authorize the following person(s) or organization(s) to **receive** my protected health information, as disclosed by the person(s) or organization(s) above:

Name / Organization: _____

Address: _____

_____

Phone #: _____ Fax #: _____

Specific descriptions of the protected health information that I authorize for disclosure:

□ All psychiatric evaluation notes in my medical file
□ All psychiatric follow up notes in my medical file
□ All psychiatric medication lists in my medical file
□ Other: (Please specify): _____

Please note, we do not release any psychotherapy notes in the medical file.

The purpose of the use for this disclosure is at the request of this individual for: _____

_____

This authorization for disclosure of my protected health information covers the period of treatment from:
□ Past Month □ Past Six Months □ Past Twelve Months □All records

This authorization is effective as of (today's date):_____ and will expire in one year from the date this form is signed.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction, and that a photocopy of this form is as valid as the original to allow for disclosure of my protected health information.

Patient/Guardian Signature:_____ Date:_____