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

Patient Name: _____ Date of Birth: _____

I authorize the following person(s) or organization(s) to **release** my protected health information and records to **Life Healing Center, PC**:

Name / Organization: _____

Address: _____

_____

Phone #: _____ Fax #: _____

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

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

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. By signing below, I acknowledge approval in the release of my medical records.

Patient/Guardian Signature:_____ Date:_____