MINDCARE WELLNESS LLC

Patient Release

Patient Name:_____D.O.B: _____

This form, when completed and signed by you authorizes the release of protected information from your clinical record to MindCare Wellness LLC.

I authorize the exchange of information between the following:

Information to be released to/from:

Name: _____

Relationship: _____

Phone _____ _____

Fax:_____

Address: _____

Information to be released to/from:

MindCare Wellness LLC.

Phone 443-418-8356

mindcarewellnessllc@gmail.com

Purpose of release:

Coordination of Care ☐ Request of the individual ☐ Legal Representation ☐ Insurance ☐ Other ☐

The authorization is only for the limited purpose of obtaining from or releasing information to, discussing my case with these individuals or companies for the specific purpose of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information. I understand that information may be shared in writing, via email, in electronic form, and/or in meetings or by telephone. This release will automatically expire 12 months from the date of signature. I understand that I can withdraw this consent at any time by submitting a written revocation to MindCare Wellness LLC. The revocation will not apply to information that has already been released. I understand that information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may then be no longer protected under the

HIPPA Privacy Rule.

_____ Patient Signature /Date

_____ Witness/ Date