



MEDICAL & MENTAL
HOLISTIC HEALTHCARE

Authorization for Release of Protected Health Information (PHI)

License #: RN188664

Patient Information

Name: _____ DOB: _____ Phone: _____

Release Information

FROM: Medical & Mental Holistic Healthcare

TO: Name/Organization: _____

Phone/Fax: _____

Purpose (check one)

Continuity of Care Patient Request Insurance/Billing

Legal Other: _____

Information to Disclose

Entire Record Psychiatric Evaluation Medication Records

Progress Notes Treatment Plan Labs

Billing Records Other: _____

Date Range (if applicable): _____

Sensitive Information (Initial if applicable)

_____ Mental Health _____ Substance Use (42 CFR Part 2)

_____ HIV/AIDS or STD Information

Expiration

1 Year from Signature Upon Completion of Request

Other: _____

Authorization

I understand I may revoke this authorization in writing at any time. Treatment is not conditioned on signing this form. I may receive a copy of this authorization.

Patient Signature: _____ Date: _____

If Representative:

Name/Relationship: _____

Signature: _____ Date: _____