HEALTHY MINDS
PSYCHIATRY SERVICES INC.

AUTHORIZATION TO RECEIVE / RELEASEA HEALTH INFORMATION

Patient Name _____ **D.O.B** _____ **Phone** _____

I Hereby Authorize the Disclosure of my Health Information from Healthy Minds Psychiatry Services, Inc. 19415 Deerfield Ave, Suite 209. Lansdowne, VA-20176. **P: 571-559-2100. F: 571-559-2101**

Release my Information To:

Name of Person/Organization Receiving Information

_____/_____

Address City / State / Zip

_____/_____/_____

Phone Number / Fax Number

/

Information to be released (mark X):

____Complete Medical Record.

____Medical Records for Specific Dates of Service, From_____,To_____

This authorization remains in effect until the information has been forwarded as requested. RIGHTS OF THE PATIENT: I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed because of this authorization may be subject to re disclosure by the recipient and may no longer be protected by federal or state law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA). I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Printed Name of Patient or Personal Representative_____Signature of Patient or Personal Representative _____Date_____.