The Present Center for Mindfulness and Healing, LLC
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# Authorization for Release of Health Information Pursuant to HIPAA

| Patient | DOB | SS# |
|---|---|---|
| Address | | |

I or my authorized representative request that my health information regarding my care and treatment be released in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996.

I understand that

1. This authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment except psychotherapy notes, and confidential HIV-related information only if I place my initials on the appropriate line. In the event of health information described below includes any of these types of information and I initial the line on the box I specifically authorize release of such information to the person(s) indicated.
2. If I am authorizing information about HIV, alcohol or drug treatment or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under Federal or State Law. I understand that I have the right to request a list of Disclosures (people who may receive or use my HIV-related information without authorization.) If I experience discrimination because of the release of disclosure of HIV-related information I may contact the Delaware State Division on Human Rights. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient except as noted above in item 2, and this re-disclosure may no longer be protected by Federal or State law.
6. This authorization does not authorize you to discuss my PHI with anyone other than the individual (S) or agencies specified below:

Name and address of entity to release this information:

___________________________________________________________________________________

Specific information to be released:

___ Medical record from ___________________ to ________________________

___ Entire medical record including patient histories, office/progress notes EXCEPT PSYCHOTHERAPY NOTES, test results, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

___ Other:_________________________________________________________

Include:

__Alcohol/drug treatment
__Mental Health Information
__HIV-related information

__________________________________________________________________

Signature

__________________________________________________________________

Dr. Jenna Tedesco