Mindfully Integrated Health, PLLC

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HIPAA RELEASE

Authorization Release of Records from Primary Care

Patient Name: _____ Date birth: _____ Phone #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Dates of Service: _____

□ **I authorize** _____ (Primary care provider) to release and disclose my protected health information to Mindfully Integrated Health for the purposes of evaluation, treatment, and health care operations.

□ **I authorize** _____ (Primary care provider) to release and disclose the following records related to my care:

Records: □ All records □ Medical Records □ Drug and alcohol related
□ Diagnostic Records □ Billing/Claims Records □ Treatment Records

Primary care contact information:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ZIP: _____

PHONE: _____ FAX: _____

You may **revoke this authorization** in writing at any time by sending written notification to:

Mindfully Integrated Health, PLLC
8585 East Hartford Drive Suite 103
Scottsdale Arizona 85255

Please note: Revocations do not apply to information that has already been disclosed or used before revocation has been received.

You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits unless this authorization is being performed solely to create information to be sent to another entity.

You have the right to receive a copy of this authorization.

This authorization expires one year from date of signing or on _____

_____ OR _____

SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

Name: _____ Relationship: _____