Healing Minds
integrative mental health

215-385-3078 www.healingminds.care
1099 General Knox Road
Washington Crossing, PA 18977

Name: _____ Date of Birth: _____
Address_____
City: _____ State: _____ Zip Code: _____ Phone:_____

☐ **I am requesting my protected health information (PHI) from Healing Minds**

OR

I authorize my PHI to be: ☐ released to ☐ obtained from ☐ exchanged with

Name of Person or Institution:_____
Address_____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax (if Healthcare Provider): _____

Special Records: I understand that information related to my diagnosis or treatment for psychiatric treatment, treatment for drug and alcohol abuse, or AIDS/HIV will only be released if I check the appropriate box(es) below:

☐ **Psychiatric Treatment** ☐ **Drug or Alcohol Abuse Treatment** ☐ **AIDS/HIV Information**

I authorize the following PHI to be released from my medical records

☐ Consultations	☐ ER Record	☐ Medication Records
☐ Discharge Instructions	☐ Evaluation	☐ Progress Notes
☐ Discharge Summary	☐ History and Physical	☐ Other: _____
☐ Diagnostic studies	☐ Lab Reports	

Covering the period(s) of care (list applicable dates of treatment): ____/____/_____ to ____/____/_____

Purpose of requested information: ☐ Coordination of care ☐ Legal ☐ Insurance ☐ Personal

Delivery Method: ☐ Verbal ☐ Written ☐ Electronic

Important: I understand that unencrypted email is not secure and therefore may be intercepted by others. I also understand that email may be misdirected and easily forwarded to unintended recipients. By choosing to receive my health information by email, I am accepting these risks.

AUTHORIZATION

I hereby authorize Healing Minds to disclose the health information as described above. I understand that my authorization will automatically expire three hundred sixty-five (365) days after the date of signature on this form. I understand that I may revoke this authorization at any time by submitting a request in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law. If I have requested to receive health information electronically, I acknowledge and accept the risks described above concerning unencrypted electronic formats. My refusal to sign this authorization will not affect my ability to receive treatment.
A copy of this signed document will be provided to you.

_____	_____	_____	_____
Client signature	Date	Witness signature	Date

_____	_____	_____
Parent/guardian signature	Parent/guardian (print)	Date

This information has been disclosed to you from records whose confidentially is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.