Mind and Motion, LLC

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION (PHI)

FAX Return phone #: 678-749-7611

Patient Name: ____ Date of Birth: ________________________

For many services, a referral is required of the patient's Primary Care Physician in order to obtain an insurance authorization for treatment. We also prefer to notify your Primary Care Physician of your visit so that coordination of care can be established.

May we share and communicate your Protected Healthcare Information with the PCP you have listed below?

Primary Care Physician:____________________ PCP Phone Number:________________________ PCP Location (City):_____________

I recognize there are additional organizations, doctors, schools, etc. that would benefit from having specific information provided to/from Mind and Motion, LLC. Or, I have an extended family member or childcare arrangement where I need to allow Mind and Motion, LLC to coordinate scheduling and billing information directly with that party. Therefore, I hereby authorize Mind and Motion, LLC to send, receive, and communicate protected healthcare information to the following parties:

Name____ Phone:____
Email: ____ Fax: ____
Street:____ City:_________________ State:____ Zip:__________
Please send/communicate the following information (check appropriate box):
☐ Psychological/Allied Health Report ☐ Progress Report ☐ Treatment Summary ☐ Scheduling/Billing Information

Name____ Phone:____
Email: ____ Fax: ____
Street:____ City:_________________ State:____ Zip:__________
Please send/communicate the following information (check appropriate box):
☐ Psychological/Allied Health Report ☐ Progress Report ☐ Treatment Summary ☐ Scheduling/Billing Information

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After giving due consideration to the extent of this release, I authorize Mind and Motion, LLC to furnish information, including photo static copies of my psychological records concerning my evaluation or treatment, to the above individual(s), organization(s) or to its agent(s), and I further agree to indemnify and hold harmless Mind and Motion, LLC from all liability that may arise from the release of the information herein requested. Any information released in response to this authorization should not be re-released to any other person(s) unless I so specifically authorize. I understand that the records released may contain alcohol and drug treatment information, medical information or psychiatric and psychological information.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it.

____ ______________________________________
Patient/Client Name (Print) Date

____ ______________________________________
Signature (Guardian Signature if Patient is under 18) Date

Mind and Motion Centers of GA ● 5050 Research Ct. #800, Suwanee, GA 30024 ● 678-749-7600 ●
www.mindmotioncenters.com *Revised — 8-10-2018*