Authorization to Release/Receive Medical Records and Medical Information

Mindful Behavioral Health, PLLC
2201 N.W. Corporate Blvd, Suite 202, Boca Raton, FL 33431-7337 Tel: 561-499-6932 Fax: 561-235-5172
Ivan Cichowicz, MD, Gretchen Garcia, MD, Marc Weiss, MD, Brenda Cooper, ARNP, Elizabeth Gutierrez, LMHC & Michael Leboe, LCSW

Patient Name:_____
(Last) (First) (Middle)

Address:_____ Apt:_____

City: _____State:_____ Zip:_____

Date of Birth:_____ SS#:_____Gender: Male Female

I authorize Mindful Behavioral Health, PLLC to **release** and **obtain** medical information **to** or **from** the following:

Name:_____Relationship:_____

Address:_____

Phone:_____ Fax:_____

Please check type of records to be released:

_____ All

OR choose from below:

_____ Psychiatric Evaluation
_____ Psychiatric Follow-Up Visit(s)
_____ Therapist Evaluation
_____ Therapist Follow-Up Visit(s)
_____ Laboratory Report(s)
_____ For Emergency Only
_____ Other_____

Please initial each item below:
_____ I understand that Mindful Behavioral Health, PLLC. will release only the minimum amount of information needed to fulfill a request.
_____ I authorize verbal communication with the above listed person.
_____ I authorize the release of any records regarding drugs, alcohol or mental health treatments.
_____ I authorize release of HIV/AIDS information and STD information whether negative or positive.
_____ I understand that I have the right to withdraw my authorization at any time, except to the extent that action has already been taken pursuant to this authorization. I understand that, if I revoke this authorization, I must do so in writing and present the written revocation to Mindful Behavioral Health, PLLC.
_____ I understand this authorization will remain in effect as long as I am a patient at Mindful Behavioral Health, PLLC.

Patient Signature:_____ Date:_____

Witness:_____ Date:_____