MINDSPRING HEALTH

49B Lenox Pointe NE, Atlanta, GA 30324
404-333-8829 (P) 800-676-6864 (F)
info@mindspringhealth.com

Authorization for Release of Information

Patient Name **Date of Birth**

I hereby authorize the communication of clinical information between Dr. A. Umair Janjua, M.D. of Mindspring Health Inc. and the following individuals:

Primary Care Physician

(initial) **Name**

Address

Phone (P) **Fax (F)**

Psychotherapist

(initial) **Name**

Address

Phone (P) **Fax (F)**

Psychiatrist

(initial) **Name**

Address

Phone (P) **Fax (F)**

Other

(initial) **Relationship / Entity**

Address

Phone (P) **Fax (F)**

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Other

(initial) **Relationship / Entity**

Address

Phone (P) **Fax (F)**

Communication may include direct verbal communication, clinical documentation including inpatient and outpatient treatment notes, discharge summaries, testing and laboratory results, and similar clinically relevant materials.

I understand that I may withdraw this consent at any time by submitting a request in writing. Please note that once the requested information is disclosed pursuant to this Authorization, Mindspring Health Inc. will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Patient or Legal Representative **Date Signed**

Print Patient Name **Date Signed**

Print Name of Legal Representative **Date Signed**

*** This authorization for release of information is good for one year after date signed, until patient revokes authorization, or until patient is discharged from treatment (whichever precedes).*