Mindspring Health Inc.
1074 Ponce De Leon Ave NE
Atlanta, GA 30306
404-333-8829 (P)
980-495-8849 (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:

_____
(initial) PRIMARY CARE PHYSICIAN: _____
Address: _____
_____
Phone /Fax Number (P)_____ (F)_____

_____
(initial) PSYCHOTHERAPIST: _____
Address: _____
_____
Phone /Fax Number: (P)_____ (F)_____

_____
(initial) OTHER: _____
Address: _____
_____
Phone /Fax Number: (P)_____ (F)_____

_____
(initial) OTHER: _____
Address: _____
_____
Phone /Fax Number: (P)_____ (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).