



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).