



Mindspring Health Inc.
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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).