

2026 Primary Care Provider ROI

This is a Release of Information (ROI) form that gives Mindful Psychiatry permission to communicate with your Primary Care Provider (PCP) about your care. Please complete and sign so we can share and request information as needed for coordination of care.

HIPAA Authorization for Release or Receive Patient Health Information to Primary Care Provider

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Please ONLY provide your PCP's information.

Patient Full Legal Name *

Patient Date of Birth *

Authorization to Release or Receive Mindful Psychiatry Medical Records or Share Information

I give permission that Mindful Psychiatry *

RELEASE my information TO:

REQUEST my information FROM:

Primary Care Provider(s)/Organization *

Contact Information for PCP: *

Information to be released or shared:

Release Dates: *

Beginning of Treatment To Current Treatment

or Specific Date(s): *

I understand by checking certain boxes below, I am giving permission to release confidential information related to drug and/or alcohol treatment, which is protected by federal law 42 CFR, Part 2, mental health conditions, and/or HIV treatment.

I consent to release information regarding the following: *

- Mental Health Records
- Alcohol or Substance Abuse Records
- HIV Records

I consent to release the following: *

- Diagnosis List
- Medication List, Current and Past
- Lab Orders and Test Results
- Psychiatric Progress Notes and Encounter Notes
- Complete Psychiatric Intake Evaluation Note
- Other (list below)

Describe Other *

The purpose of this authorization is (check all that apply): *

- Sharing Information
- Coordination of Care
- Other

Describe Other: *

This information may be shared by: *

- Verbal Communication
- Written Communication
- Copy of Records, Clinical Documentation, Notes, Labs, other as detailed above
- Other communication as may be necessary

This authorization ends: *

When Patient Provides in Writing to End Release

Choose Date for Authorization to Expire *

My Rights as a Patient

- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back.
- I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
- I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
- I will receive a copy of this authorization after I have signed it at my request. A copy of this authorization is as valid as the original

Signature: *

Date:

If signed by Legal Representative other than patient, please indicate below your name and relationship to patient *