MAURIE MINTZ, M.D., L.L.C.
ADULT PSYCHIATRY AND PSYCHOTHERAPY

1784 CENTURY BLVD. SUITE A
ATLANTA, GA 30345

P: 404-795-2097
F: 404-393-5203

Authorization to Release Healthcare Information

Patient Name: _____

Date of Birth:_____ Social Security # _____

I request and authorize Maurie Mintz, M.D. to receive/release my protected healthcare information (including mental health diagnosis and treatment) to/from:

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____

This request and authorization applies to :

__ All Healthcare Information
__Psychiatric Evaluation
__ Progress Notes
__ Lab Results
__Billing Information
__ Verbal Discussion of Case
__ Case Summary
__ Healthcare information relating to the following treatment, condition, or dates:_____
Other:_____

The purpose of this release is for:

_____

__ yes __ no I authorize the release of any information regarding drug and/or alcohol treatment to the person(s) listed above.

Expiration of this release:_____

Patient Signature:_____ Printed Name:_____

Date:_____