Cultivating Resilience, LLC  **IV Hydration Therapy**

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(Including Medical and Mental Health Records)

Patient's Name: _____ Date of Birth: _____

Previous Name(s): _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Federal Regulation, 42 CFR Part 2, requires that a description of the amount, the kind of information that is to be disclosed, and the purpose for this disclosure be provided.

This request and authorization applies to: ☐ All records available ☐ All correspondence

Or the specific records indicated here:

☐ Psychiatric Evaluation
☐ Diagnosis
☐ Summary of Treatment
☐ Medications
☐ Psychological Assessment
☐ Other (specify)_____
☐ Psychological Testing
☐ School Evaluation
☐ History
☐ Legal issues/concerns
☐ Performance

and is to be released for the purpose of: ☐ Continuity of care ☐ Other: (specify) _____

By checking the boxes below, I specifically authorize the voluntary release of the following types of medical records, if such records exist.

☐ Yes ☐ No I authorize the release of my HIV/AIDS records, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

This consent to release is valid for 90 days, or until otherwise specified, and thereafter is invalid. Specify date, event, or condition on which permission will expire:

_____

I understand that at any time between the time of signing and the expiration date listed above I have the right to revoke this consent to the extent that information has already been released based on this authorization.

Patient Signature:_____

Date Signed:_____

Relationship to patient: _____