1407 S. Elliott Ste B
Aurora, MO 65605
417-440-0826

Authorization to Release and Obtain Confidential Health Information

Identifying Information:

Name: _____ Phone: _____

DOB: _____ Parent/Guardian (If applicable): _____

I hereby authorize the following to send, as promptly as possible, the records as indicated below. Additionally I authorize MindBody Wellness, LLC to communicate and to provide confidential health Information to the named person/agency below. Communication may include telephone communications. I understand that no services will be denied me if I do not wish to sign this authorization. In consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom. I have been Informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer and I accept these.

I understand that I may refuse to sign this authorization and that this will not affect my treatment or payment for health care. I may also revoke this authorization at any time before the Information I have requested is released by providing written notice of revocation as specified In the Notice of Privacy Practice.

Agency:

Name: _____

Address: _____

Phone: _____ Fax: _____

Information to Include:

- □ Inpatient or Outpatient treatment records for physical/psychological, psychiatric, or emotional illness Dates: _____
- □ I understand that this may include substance abuse and/or HIV related information unless otherwise indicated here:_____
- □ This Authorization expires on _____. If blank then date Is one year after signature date.

This information may be mailed to the address as given in the letterhead with Attention: Stacey Maples, PhD or faxed to 888-602-7956

_____

Signature of client Printed Name Date

I, the mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____

Signature of professional Printed Name Date