Authorization for Release of Medical Records

Name of Facility or Person____

Address____

Telephone (   )______________________________   **Fax (   )**______________________

Purpose of Release

You are hereby authorized to release to **Functional Mind LLC** information from my medical, psychological and other health records, with

___ no limitation placed on history of illness or diagnostic or therapeutic information, including furnishing photocopies of all written documents pertinent thereto.

__limitedto:____
____

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records (must check off yes/no):

Mental health yes______ no_______

Alcohol or drug abuse yes______ no ______

Communicable disease related info (including HIV) yes______ no_______

Genetic testing yes______ no ______

This authorization can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release Functional Mind LLC from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be valid as the original.

I understand that there may be a fee for this service depending on the number of pages photocopied. However, no such fee will be charged if these records are requested for continuing medical care

Name____**DOB**____/_____/________

Signature____**Date** ______/_____/_______

Send to:

Functional Mind LLC, 250 Wampanoag Trail, Suite 305, East Providence, RI 02915

Phone: (401) 270-4541   **fax (401) 270-4081**