Mindful Medicine of New England, LLC **225 Providence Pike Putnam, CT 06260 Ph. (860) 255-4317**
Fax (860) 924-7248

Authorization to Use or Disclose Protected Health Information

PATIENT INFORMATION

Name: _____. Date of Birth: _____

Full Address: _____

Phone: _____

I hereby authorize Mindful Medicine of New England, LLC to (Check Appropriate Box(es):

- ☐ **Release information to and /or**
- ☐ **Obtain information from**

Name:_____**Address**:_____

_____ **Phone**:

_____. **Fax:** _____

Dates of Information to be released: _____

Purpose for release of information: Information related to Mental or Physical Health; Coordination of Care _____ (please initial indicating that you agree to the above purpose)

I do NOT want information on the following disclosed: (check all that apply)

- ☐ Sexually Transmitted Diseases.
- ☐ AIDS/HIV Status
- ☐ Sexual Abuse
- ☐ Substance Use or Abuse

1. By signing this form I understand that I am authorizing Mindful Medicine of New England, LLC to release or obtain my protected health information (PHI) as defined under 45 CFR 164.501, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as described below to the following person(s) or organization(s)
2. I understand that if the person(s) or entity that receives this information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Mindful Medicine of New England, LLC, its employees and my providers from all liability arising from this disclosure of my health information.
3. This Consent will expire one (1) year from the date signed below. I understand that I may revoke this authorization by notifying Mindful Medicine of New England, LLC in writing. I understand that any previously disclosed information would not be subject to my revocation request.
4. I understand that I may refuse this authorization and that my refusal to sign will not affect my ability to obtain treatment

Signature of Patient, Legal Guardian, or Representative Date:

_____

Print name of Patient, Legal Guardian or Representative Date: