HEALING MINDS

Psychiatric-Mental Health Nurse Practitioner

Release of Information (ROI)

I authorize Healing Minds to release or obtain my protected health information (PHI) to/from the individual or organization listed below for the purpose of coordination of care. I understand I may revoke this authorization at any time in writing.

Patient Full Legal Name:

Date of Birth (MM/DD/YYYY):

Recipient (Name/Facility):

Phone/Fax:

Information to be Released:

Signature (Typed Name):

Date: