HEALTHY MINDS
Psychiatric Services

**Okemos Office:** *2390 Woodlake Dr. Ste. 380, Okemos, MI 48864*
**Brighton Office:** *4763 S Old US 23 Ste. C1, Brighton, MI 48114*

# Medical Information Release Form
## *(HIPAA Release Form)*

Patient's name: _____ DOB:_____

## ***Release of Information***

[ ] I authorize Healthy Minds to discuss my medical information with the following people:

[ ] Spouse _____

[ ] Child(ren)_____

[ ] Other _____

[ ] Information is not to be released to anyone.

*By signing below, I acknowledge that my medical information discussed, or disclosed in relation to my health needs. I understand that my medical information is protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization and must do so in writing and present this written revocation to the office of Healthy Minds, Zulfiqar Ahmed M.D. Furthermore, I understand that once the information is disclosed per my authorization, the information may be re-disclosed by the recipient in accordance with applicable laws and regulations and it may not be protected by federal or state privacy regulations. Finally, I understand that that there may be grounds for denial of access, determined by Healthy Minds, according to 45 CFR 164.524(a)(2) and 45 CFR 164.524(a)(3) under HIPAA.*

## ***Messages***

Please call [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____