



MINDFULNESS
HOLISTIC WELLNESS & HEALING
210 2ND Street St. Marys, WV 26170 (304) 699-1419

Consent for Release of Information

Name: _____ SSN: _____ DOB: _____

Address: _____

I do hereby authorize:

Jessica Fox, M.Ed., LPC and _____

Information to be shared:

- | | |
|---|--|
| <input type="checkbox"/> 1) Social History / Intake Summary | <input type="checkbox"/> 10) Medication Records |
| <input type="checkbox"/> 2) Psychological Tests and Evaluations | <input type="checkbox"/> 11) Diagnosis |
| <input type="checkbox"/> 3) Psychiatric Evaluations | <input type="checkbox"/> 12) Alcohol/Substance Abuse/Dependence |
| <input type="checkbox"/> 4) Education - Vocational assessments | <input type="checkbox"/> 13) Work History issues |
| <input type="checkbox"/> 5) Medical exams - records | <input type="checkbox"/> 14) Treatment issues |
| <input type="checkbox"/> 6) Verbal reports from counseling sessions | <input type="checkbox"/> 15) School records |
| <input type="checkbox"/> 7) Laboratory tests, xrays, EKG reports | <input type="checkbox"/> 16) Compliance, Attendance, Participation |
| <input type="checkbox"/> 8) Admissions/Discharge summaries | <input type="checkbox"/> 17) other: _____ |
| <input type="checkbox"/> 9) Counseling notes | |

**PLEASE SUBMIT ALL RECORDS TO FAX (304) 586-6424
OR EMAIL whitney@movmindfulness.com**

This information is disclosed from records whose confidentiality is protected by Federal Law (42CFR, part 2), prohibits further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or institutions receiving it and no longer protected by the Federal Privacy regulations.

I understand that I may revoke this authorization by notifying Mindfulness, LLC at 210 2nd Street, St. Mary's, WV 26170 in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on the actions already taken by Mindfulness, LLC on this authorization

Date (expires 1 year)

Signature of minor child (12 or older)

Signature of Parent/Guardian

Witness

Signature of Patient