MINDFULNESS
HOLISTIC WELLNESS & HEALING

210 2ND Street St. Marys, WV 26170
Phone: (304) 699-1419 Fax: (304) 586-6424

Consent for Release of Information

Name: ________________________________ **SSN:**_____________________ **DOB:**_____________

Address: ____

I do hereby authorize:

Osric Malone-Prioeau and ____

Information to be shared:

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

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. Marys, 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

____
Signature of minor child (12 or older)

____
Date (expires 1 year)

____
Signature of Parent/Guardian

____
Witness

____
Signature of Patient