Rebecca Gladding, MD
Medical Director

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Authorization to Release Records

Patient name: ________________________________ Date of Birth: _______________ Last 4 of SSN: ____________

This form, when completed and signed by the patient or guardian, authorizes Mindful Wellness Maui LLC/Rebecca Gladding, MD to release protected health records to the person/entity you designate below and for the person/entity you designate below to release protected health records to Mindful Wellness Maui LLC/Rebecca Gladding, MD. This allows Mindful Wellness Maui LLC/Rebecca Gladding MD and the person/entity identified to discuss your care and share documents with your signed permission.

Name of Recipient/ Releaser of Information	
Role/Relationship	
Address	
Telephone	
Fax	

I authorize Mindful Wellness Maui LLC and/or Rebecca Gladding, MD, to release and/or receive the following medical information:

☐ Entire Medical Record ☐ Initial Evaluation ☐ Progress Notes ☐ Medication Record
☐ Treatment Plan ☐ Lab Results ☐ MRI Results ☐ Psychological Testing
☐ EEG Results ☐ Summary of Diagnostic and Treatment Information

I also give special permission to Mindful Wellness Maui LLC/Rebecca Gladding, MD and the person/entity above to release any information regarding the following protected health information classes:
☐ Psychiatric Treatment (Initial ____) ☐ Substance Abuse (Initial _____) ☐ HIV Medical Info (Initial ____)

Reason for Disclosure:
☐ Continuity of Care/Care Coordination ☐ Disability Benefits (fee may apply)
☐ Other request (fee may apply): ☐ Attorney ☐ Patient/guardian request ☐ ________________________

Right to terminate/revoke authorization: This authorization shall remain in effect for one year unless it is revoked sooner in writing.You have the right to revoke this authorization in writing, at any time, by sending such written notification to our office address. Your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to information to process a claim.

Potential for Re-Disclosure: I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by HIPAA Privacy Rules. It may not be possible to ensure your right of privacy once the information is released to that third party.

____________________________________ / ____ _________
Signature of patient or legal representative Printed name Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided: ____

____________________________________ / ____ _________
Signature of witness Printed name Date