Stefanie Lawson, LCSW
The Mindfulness Space Psychotherapy Services, P.L.L.C.
717 Green Valley Rd. Suite 200 Greensboro, NC 27408
Phone: (336) 916-1584
Email: stefanie@themindfulnessspacetherapy.com

Authorization for Two-Way Exchange of Health Information

At The Mindfulness Space Psychotherapy Services, we understand that utilizing a multidisciplinary approach to treatment, which involves maintaining as needed communication with all of your healthcare providers, is beneficial to your long-term recovery. Please take a few moments to complete the following Two-Way Exchange of information form.

Client Information:

Client's Name:
_____

Date of Birth: _____ Age: _____

Address:
_____

City: _____ State: _____ Zip:_____ County:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email:
_____

I give the Mindfulness Space Psychotherapy Services, PLLC permission for disclosure of my protected health information and communication between the individuals listed below:

Provider Information:

Provider Name: _____

Address:
_____

City: _____ State: _____ Zip:_____ County:_____

Telephone: _____ Fax #: _____ Email: _____

Purpose for the authorization:

__Referral __Coordination of care __Other (specify): _____

The information exchange covers the period of my healthcare from:

Specific date(s): _____ to _____ OR All past, present and future encounters/visits

Information to disclose (check all that apply):

__Medical Records (ED, History & Physical, Operative Record, Discharge Summary, Consultations, Lab results, Pathology/Radiology reports, Procedure Notes, Problem List and Medications)

__Treatment plan

__Behavioral/Mental Health Communications (psychiatrist; psychologist; clinical nurse specialist; educational, marriage, family, rehabilitation, or mental health counselor)

__Psychological Evaluation

__Substance Use History, SA Assessments, Drug testing results

__Other (specify): _____

By signing this authorization form, I understand that:

-I have the right to withdraw my authorization at any time
-I have the right to revoke this authorization
-Authorizing the disclosure of my health information is voluntary.
-I can refuse to sign
-Substance Abuse Records are Protected by Federal Confidentiality Rules 42.C.F.R. Part 2: FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURES OF THIS INFORMATION UNLESS DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY 42.C.F.R. PART 2.

Client Signature/Date:

____

Parent/Guardian Signature Date (If under 18):

____

Authorization Revocation:

Client Signature/Date:

____

Parent/Guardian Signature Date (If under 18):

____