Authorization for Release of Mental Health Information via Electronic Transmission

This completed form authorizes the disclosure and/or use of personal health information about you.
Failure to complete all sections may invalidate this authorization.

Patient Last Name	Patient First Name	Patient Date of Birth
Patient Phone #	Patient Email	

I AUTHORIZE HPA/LiveWell TO DISCLOSE MY PERSONAL HEALTH INFORMATION TO:

Name of Provider/Person			Office/Affiliation			
Email			Phone		Fax	
Relationship	Parent ☐	Partner/Spouse ☐	Primary Care ☐	Med Prescriber ☐	Dietitian ☐	Other (specify) ☐

I AUTHORIZE HPA/LiveWell TO RELEASE THE FOLLOWING INFORMATION:

Please release information of my care for this period:	From Start Date	To End Date
For the Purpose of:		
I request this Authorization to be valid and in effect until:	Termination Date	

Comments:

I request that HPA/LiveWell release health information regarding my care and treatment as identified on this form. I understand the risks of sending this information electronically. I understand I have the right to revoke this authorization at any time by contacting HPA/LiveWell in writing. All my questions about this form have been answered and I have retained a copy of this form for my records.

Signature of Patient/Guardian	Date Signed
Printed Name	If not patient, relationship to patient