THE CENTER FOR MINDFUL EXPLORATION
1111 Mooty Bridge Road, Ste A / PO BOX 800154
LAGRANGE, GA 30240

AUTHORIZATION FOR RELEASE OF INFORMATION PRIMARY CARE PHYSICIAN (REQUIRED BY INSURANCE)

I, ____, give full authorization to provide/exchange information regarding my mental health information to/with:

____

Name (Primary Care Provider)

____

Phone Number

____

Street Address

____

City, State, Zip Code

for the purpose(s) of:

coordination of care

____

____

I understand that authorization shall remain valid from the date of my signature below and ending one year from the date this authorization is signed.

I have been informed that I may revoke this authorization by written communication at any time.

I certify that this form has been fully explained to me and that I understand its contents.

____ ________________________

Signature of Client or Legal Guardian Date of Authorization