MIND BODY INSTITUE OF CHESTER COUNTY
M. ANJUM IRFAN, M.D.
423 EXTON COMMONS, EXTON, PA 19341 (Ph: 610 - 524- 2444)

Authorization to disclose or obtain confidential client information

I hereby authorize **Mind Body Institute of Chester County** to disclose / obtain protected medical information as described below from the records of:

Patient's Last Name: _____ First: _____M. Initial: _____

Address: _____

Date of Birth: _____ Telephone Number: _____

To be disclosed to/obtain from: Name: _____
(Person/organization disclosure is being made to/obtained from)
Address: _____Telephone#_____

Fax #:_____

Reason for Disclosure/Obtaining Information: _____*Coordination of care*_____

I understand that:

- This authorization may be revoked at any time by writing, except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization revoking it will only prevent further disclosure.

- Information (except drug and alcohol information) disclosure pursuant to this authorization may be subject to re- disclosure by the individual /organization identified.

- **Mind Body Institute of Chester County** and its designee are hereby released from any legal responsibility or liability for disclosure of the specified information.
- The Authorizations may include Mental Health, Drug & Alcohol Abuse and or HIV related information.

The information to be disclosed:

*****Check in box next to information you wish to have disclosed.

Financial information		Medication Information	
Medical Diagnosis/treatment		Mental Health Diagnosis	
Laboratory record		Progress Notes/Treatment Plans	
Psychiatric Evaluation		Psychotherapy notes	

(Two years from today.)

Authorization: Start Date_____ End Date_____

Signature of Client/Personal Representative: _____ Date_____

Guardian Signature _____ Date _____

Signature of Witness_____ Date_____