Lauren Johnson, MMFT
Living Water 2670 Memorial Blvd. B *Murfreesboro, TN 37129
615.390.3713 * lauren@livingwatermft.com

General Medical Records Release and Authorization for Use/Disclosure/Receipt of Protected Health Information

Please complete the following information:

Client Name: _____ SSN#_____-_____-_____
Address: _____
Phone: _____ Date of Birth:_____/_____/_____

For Lauren Johnson, dba Living Water to RECEIVE information:

I authorize the custodian of records, _____, to disclose/release the following information* (check all applicable) to Lauren Johnson, dba Living Water.

- ☐ All records
- ☐ Pharmacy/prescription records
- ☐ Abstract/Summary
- ☐ Laboratory/pathology records
- ☐ Billing records
- ☐ Other (describe specifically)_____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis,drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s):_____

Please send the records listed above to (use additional sheets if necessary):

Name: Attn: Lauren Johnson, MMFT
Living Water
Address: 2670 Memorial Blvd. B
Murfreesboro, TN 37129
Phone: (615) 390-3713
email: lauren@livingwatermft.com

For Lauren Johnson, dba Living Water to DISCLOSE/RELEASE information:

I authorize the custodian of records, Lauren Johnson, dba Living Water, to disclose/release the following information*(check all applicable) to, _____ [Name(s) of recipient(s)].

- ☐ Discuss via phone
- ☐ Written Progress Notes Summary (legal documentation only**)
- ☐ Billing records
- ☐ Pharmacy/prescription records
- ☐ Other (describe specifically) _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis,drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*
***Additional Fee**

These records are for services provided on the following date(s):_____

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For my health care
- ☐ For employment purposes
- ☐ For payment/insurance
- ☐ Other:

This authorization shall expire no later than: ___/___/___ or upon the following event _____ (whichever is sooner), and may not be valid for greater than one year from the date of signature.
I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date

_____
Printed name of patient representative: Representative's authority to sign for patient, *(i.e parent, guardian, power of attorney for healthcare, executor)*