Shanti Wellness, LLC

28 Millburn Avenue, Suite 7
Springfield, NJ 07081
Phone: 908-447-8593
Fax: 1-877-919-0530
www.shantiwellnessllc.com

Consent for Release and Exchange of Confidential Information

I, _____ _____
(Name of Patient- Please Print) (Date of Birth)

hereby authorize Shanti Wellness, LLC to ☐ **Disclose To** OR ☐ **Receive From:**

_____
(Name and Title of Person or Agency Receiving or Disclosing Information)

_____
(Address including Zip Code)

_____ _____
(Telephone Number) (Fax Number)

☐ **Mail the Records** ☐ **Fax Records to Number Above** ☐ **Discuss via Phone**

The information to be exchanged should include the following (Check each item):

_____ Progress Notes
_____ Dates of Service
_____ Treatment Plan
_____ Admission Psychiatric Evaluation
_____ Medications
_____ Consultation Notes
_____ Radiology Reports
_____ Psychiatric Evaluation
_____ Psychological Evaluation
_____ General progress/ Condition
_____ History and Physical
_____ Discharge Summary
_____ Laboratory Reports
_____ EKG or EEG Reports
_____ Other (specify): _____
_____

The purpose or need for the exchange and disclosure of this information is to (check all that apply):

_____ Coordination of Treatment _____ Medical Follow-up _____ Continuing Care
_____ Other (state purpose clearly): _____

I understand that if the person or agency that receives my information is not a health care provider covered by the HIPAA privacy regulations, then the information above may be redisclosed and is no longer protected by HIPAA regulations.

I understand that written notification to cancel this authorization may be sent to Shanti Wellness LLC at the address above. This cancellation will not apply to any information that was previously disclosed prior to Shanti Wellness LLC receiving the cancellation notice.

I understand that this disclosure may include information regarding substance abuse, alcoholism, alcohol abuse, psychiatric and mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV as regulated by Federal Statute 42 CFR Part 2.

_____	_____	_____
Patient Signature	**Patient Printed Name**	**Date**
_____	_____	_____
Parent/Guardian Signature	**Parent/Guardian Printed Name**	**Date**