Better Mood Clinic
of South Georgia, LLC
2935 N. Ashley, Bldg F
Valdosta, GA 31602
Ph (229) 333-2273; Fax (229) 506-5403

Request for Protected Health Information (PHI)

Date: _____

I, _____, am requesting: (a letter / disability information / completion of military documents / special needs documents or _____) from my provider (s), _____.

The purpose of the documentation or PHI requested is to:

_____

_____

_____

_____

The recipient of the documentation is: _____

I want the documentation sent to or faxed to: _____

I need the documentation (providers need at least 1 wk. notice) by:_____

I also understand that depending on the nature of the documentation, the investment of the provider's time and liability of the provider's credentials, the fees below will be added to the final cost of the requested PHI.

I request the PHI to be released and sent in the following format:

□ ***Letter*** to be picked up at the Better Mood Clinic (preliminary fee of $50; final fee will be dependent upon the amount of time spent in preparation). This $50.00 non-refundable down payment is due now.

□ ***Paper documents*** (a fee of $1.00 will be charged for each page of PHI)

□ ***Fax transmittal*** (a fee of $1.00 will be charged for each page of PHI)

□ ***Electronic transmittal of records*** i.e. E-mail (preliminary fee of $25; final fee will be dependent on the amount of time spent in retrieval)

Lastly, my signature below represents understanding of the above, as well as my permission to release this requested PHI to the recipient identified above.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

[Note: As requested a copy of the signed authorization must be provided to the patient or their representative]

"A new day … a new way"