



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 \$75; final fee will be dependent upon the amount of time spent in preparation). This \$75.00 non-refundable down payment is **due now**.
- Forms of any kind (military PCS, disability, school, etc.) requiring a provider's signature, records review and/or time spent will be a minimum of \$25 **due now**.
- Paper documents** (a fee of \$1.00 will be charged for each page of PHI) **due at time of pick-up**.
- Fax transmittal** (a fee of \$1.00 will be charged for each page of PHI) **due before fax is sent**.
- 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). This \$25.00 non-refundable down payment is **due now**.

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"