Healing Growing Wellness

TherapyMatters

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Client/Previous Names

Street Address

City, State, Zip

Date of Birth

Authorizes Release Of Protected Health Information between:

Therapy Matters LLC
Name of Health Care Provider/Plan/Other

Name of Health Care Provider/Plan/Other

1070 W. Century Dr, Ste. 200 AND
Street Address

Provider/Plan/Other - Street Address

Louisville CO 80027 AND
City, State, Zip Code

Provider/Plan/Other - City, State, Zip Code

Information To Be Released:

___ Diagnosis and Treatment
___ Admission History, Physical, Discharge Summary, Operative Reports
___ Psychological/Neuropsychological Testing/Consultation
___ Physical Exam, Lab Studies, X-Rays, EKG, EEG
___ Other (Specify):

___Drug/Alcohol Use/Abuse
___ Educational History
___ Consultations
___Prescriptions

_____

Purpose For Need Of Disclosure: (Check applicable categories)

___ Assessment
___ Continuity of Care
___ Other (Specify): _____
___ Service Planning
___ Legal Investigation or Action
___ Personal
___ Further Medical Care

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Your Rights With Respect To This Authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting THERAPY MATTERS LLC Privacy Officer. **Right to Receive Copy of This Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization -** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: THERAPY MATTERS LLC Privacy Officer. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) or six months following termination of treatment. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Client/Parent/Guardian Signature **Date** **Witness Signature** **Date**