AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

_____ _____
Name of Patient/Previous Names | Street Address

_____ _____
Birth Date | City, State, Zip

AUTHORIZES:
Erin M. Wick, MA, LPC, CACIII
Managing Member of Perspectives Counseling, LLC
Name of Health Care Provider

1333 W. 120th Avenue, Suite 218
Street Address

Westminster, CO 80234
City, State, Zip Code

RELEASE OF PROTECTED HEALTH INFORMATION TO:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

INFORMATION TO BE RELEASED MAY INCLUDE THE FOLLOWING:

____ Assessment and Diagnosis
____ Treatment Plan
____ Treatment Progress
____ Other (Specify): _____
____ Drug/Alcohol History, Assessment, Diagnosis, and Treatment
____ Medication Regimen
____ Discharge Summary

PURPOSE FOR NEED OF DISCLOSURE: (Check all applicable categories)

____ Assessment ____ Service Planning ____ Continuity of Care ____ Other (Specify): _____

*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 redisclosed 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 asking Erin M. Wick, MA, LPC, CACIII, Managing Member of Perspectives Counseling, LLC. **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 Erin M. Wick, MA, LPC, CACIII, Managing Member of Perspectives Counseling, LLC. I am aware that my withdrawal is not retroactive and therefore, 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** if left blank, six months following termination of treatment with Erin M. Wick, MA, LPC, CACIII of Perspectives Counseling, LLC.

I have had an opportunity to review and understand the content of this authorization form. By initialing below and signing this authorization, I am confirming that it accurately reflects my wishes. _____

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