AUTHORIZATION FORM / RELEASE OF RECORDS/INFORMATION

227 Midland Avenue, Suite 13B Basalt, Colorado 81621 970.456.6354 FAX: 970.928.0880

PATIENT:

Name: _____

Address: _____

City, State & ZIP: _____

Date of Birth: _____

I AUTHORIZE:

Linda Carlson Shaw

227 Midland Avenue, Suite 13B

Basalt, Colorado 81621

970.456.6354 FAX: 970.928.0880

_____ To release &/or

_____ To receive information which may include protected health information under HIPAA. I request release of the following:

_____ Complete clinical records and information (*Does not include psychotherapy notes*)

_____ Relevant ongoing treatment information

_____ Laboratory reports

_____ Other, please specify: _____

_____

I am requesting the above person/agency to release this information for the following reasons:

_____ At the request of the individual. ("At the request of the individual" is all that is required if you are my patient)

_____ To another health care provider for the purpose of obtaining health care.

_____ Other, please specify: _____

_____

The information should be released and/or released by:

_____
Name of Person/Agency/Institution

_____
Address

_____
City State ZIP

_____
Phone FAX

This authorization shall remain in effect for 12 months or until the date printed here: _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing person/agency address. However, your revocation will not be effective to the extent that the person/agency has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my provider generally may not condition health services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____

Signature of Patient Date