LARSON
MENTAL HEALTH

4770 Baseline Rd., ste 200,
Boulder, CO 80303

155 East Boardwalk Dr., ste 400
Fort Collins, CO 80525

1745 Shae Center Dr., ste 400,
Highlands Ranch, CO 80129

8354 Northfield Blvd., third floor,
Denver, CO 80238

102 South Tejon St., ste 1100
Colorado Springs, CO 80903

# RECORDS RELEASE

Patient Authorization for Disclosure of PHI (Not for Psychotherapy Notes)

Patient Name: _____

Patient Address: _____

Patient DOB: _____ Patient Phone: _____

_____ (initial) I give permission to Larson Mental Health to disclose my complete health record other than psychotherapy notes (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse (excluding records subject to the Confidentiality of Alcohol and Drug Abuse Patient Records regulations at 42 CFR Part 2)), **except for the following (complete, if applicable)**:

_____.

**To the following individuals (Persons/Entities authorized to receive the information)**:

_____

**Required: Recipient's street address, phone number and fax number:**

_____

Purpose of requested use or disclosure: Patient request.

This authorization will remain in effect until the termination of my relationship with Larson Mental Health. I understand that I have the right to revoke this authorization, in writing, at any time, except where uses and disclosures have already been made based upon my original consent. I agree that revocation must be communicated in writing to Larson Mental Health, Inc.

I understand that authorizing the disclosure of this information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria. I understand I am entitled to a copy of this document in its complete form. I understand that it is possible that information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient Signature: _____Date:_____

Print your name: _____

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If this form is being completed by a person with legal authority to act an individual's behalf as a Personal Representative in compliance with HIPAA, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form:_____

Signature of person completing this form: _____

Description of Personal Representative's Authority: _____