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 Request

Effective Date: _____

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) (Not for Psychotherapy Notes)

Patient Name: _____

Patient Address: _____

Patient DOB: _____ Patient Phone: _____

1. Authorization: I (**patient**)_____authorize

(**previous health care provider**) _____ to use and disclose

the protected health information described below to a business entity known as Larson Mental Health, Inc.

Please fax the requested medical records to Larson Mental health at **888-437-8409** or email them in a secure, HIPAA-compliant manner to admin@larsonmentalhealth.com.

2. Effective Period. This authorization for release of information covers records pertaining to all past, present, and future periods of health care in any and all formats or portions (examples of formats are paper, digital, internet).

3. Extent of Authorization. I authorize the release of 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)**:

_____

4. Use/Purpose. At my request.

5. Termination. This authorization shall be in force and effect until the termination of my relationship with Larson Mental Health, Inc., at which time this authorization form expires.

6. Revocation Rights. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I agree that revocation must be communicated in writing to the healthcare provider.

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7. Benefits. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. Disclosure. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that authorizing the disclosure of this information is voluntary. I understand I am entitled to a copy of this document in its complete form.

Patient's Signature (or Personal Representative): _____

Printed Name: _____

Date: _____

Description of Personal Representative's Authority: _____