Release of Information or Authorization

Indicate your provider below:

◯ **Scott Gregory, LMFT** ◯ **Marta McKay, LPC, CAC III** ◯ **Jennifer Wilson, PhD** **Affiliates:** ◯ **Jeffrey Wentz, MD**

4760 Flintridge Drive, Suite 250 Colorado Springs, CO. 80918
(719) 574-6562 (Main Office) Fax (719) 570-0386

Name:_____ **Birth Date:**_____
Address:_____
Phone:_____ **Social Security Number:**_____

The purpose of this form is to release Health Care Information to be ___◯ **sent to,** ___◯ **received from, or** ___◯ **two-way communication**, both verbal and written, between above provider, and the following health care / mental health / substance abuse / educational agencies or providers:

Person/Agency **Address** **Phone**

_____

_____

_____

_____

For the purpose(s) of (specify): ☐ Continuity of care ☐ Treatment ☐ Therapy ☐ Payment or Financial Operations

Special information being requested includes (specify, including dates if applicable)

_____

_____

- If "treatment", "payment", or "operations" is checked, this form is a "release" of information and if I refuse to sign it, the Provider can withhold treatment, payment, enrollment, or other eligibility benefits.
- Please see the HIPAA Notice of Privacy Practices for this office which was provided to you at registration for your rights concerning release of protected information.
- If this is an authorization the above provider will provide me with a copy if I so request.
- I understand that, unless lined through, information to be released / authorized may include information regarding the following condition(s):
- o Drug Abuse Psychiatric Conditions / Treatment
- o Alcoholism HIV / Auto Immune Deficiency Syndrome (AIDS)
- I understand that by releasing this information to other parties, it may not be protected by the HIPAA regulations.
- I understand that I may revoke this release / authorization at any time by giving written notice to the above provider, except to the extent that action has already been taken to comply with it. Without such revocation, this release / authorization **will expire on / / (date), or if left blank, one year from the date of my signature**, or as of the action or event of _____.

_____

Signature of patient **Print Name** **Date**

_____

Signature of Parent/Legal Representative **Print Name** **Relationship to Patient** **Date** (9/16)