Come Home to Yourself™

3470 S. Sherman St., Suite 3 - Englewood, CO 80113
303-481-3489 PHONE 720-535-4664 FAX
www.balancedmentalwellness.com

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient:

Name of Patient/Previous Names ______________________

Street Address ______________________

Birth Date/Medical Record Number ______________________

City, State, Zip ______________________

Authorizes Exchange of Protected Health Information Between:

Balanced Mental Wellness
Name of Health Care Provider/Plan/Other

____
Name of Health Care Provider/Plan/Other

3470 S. Sherman St. Suite 3
Street Address

____
Street Address

Englewood, CO 80113
City, State, Zip Code

____
City, State, Zip Code

Information To Be Released:

X Psychiatric History, Including diagnosis and treatment
X Admission History, Physical, Discharge Summary, Operative Reports
X Psychological/Neuropsychological Testing/Consultation
___ Physical Exam, Lab Studies, X-Rays, EKG, EEG
___ Other (Specify):
X Drug/Alcohol History and Treatment
___ Educational History
___ Consultations
X Prescriptions

____

Purpose For Need Of Disclosure: (Check applicable categories)

X Assessment
X Continuity of Care
___ Other (Specify):
X Service Planning
___ Legal Investigation or Action
___ Personal
___ Further Medical Care

____

I understand that in compliance with federal confidentiality rule set forth in 42 CFR Part 2, and HIPAA, mental health treatment records maintained by Balanced Mental Wellness are confidential and will not be released without written consent from the individual or his or her personal representative. 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 contacting Balanced Mental Wellness. **Right to Receive Copy of 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 Balanced Mental Wellness. I am aware that my withdrawal 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.

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Expiration Date: This authorization is good for two years from the date signed.

___I have had an opportunity to review and understand the content of this authorization form.

________________________________ ________________________

Patient or Guardian Signature Date

________________________________ ________________________

Witness Signature Date