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** Tel: (720) 347-8559 ** www.CenterForValuedLiving.com ** Fax: (720) 207-6885 **

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____
Address: _____ City, State, Zip: _____
Phone: _____ Today's Date: _____

I authorize the Center for Valued Living, PLLC:

to release information to

to obtain information from

Name of Person, Provider or Facility

Address

City, State, Zip Code

Phone # / Fax # (Include area code)

PURPOSE OF THIS REQUEST: (check one) Continued Healthcare Insurance Personal Legal
 Social Security / Disability Psychological Testing Other

TYPE OF RECORDS / COMMUNICATION AUTHORIZED: (check all that apply)

- Psychiatric/Psychological Evaluation and/or Treatment
- Medical Evaluation and/or Treatment
- Disordered Eating Evaluation and/or Treatment
- Drug/Alcohol Evaluation and/or Treatment
- Verbal Communication with Person, Provider, or Facility

SPECIFIC INFORMATION AUTHORIZED: (select all that apply)

- Assessment Reports Clinical Notes Laboratory Test Results: _____
- Diagnostic Impression Discharge Summary Consultation Reports
- Treatment Summary/Plan Historical Information Medical Records: _____
- Other: (please describe) _____

Please sign 2nd page in order for this document to be legal...

SPECIFIC INFORMATION NOT AUTHORIZED: (please describe thoroughly) _____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. My authorization will expire:

- When the requested information has been sent/received.
 90 days from this date. Other: _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire:

- When I am no longer receiving services from the Center for Valued Living, PLLC.
 One year from this date. Other: _____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to the Center for Valued Living, PLLC, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed. In general, Center for Valued Living, PLLC cannot prevent information from being released to a third party upon disclosure to the person, provider, or facility indicated by you.
- If I have not authorized information to be disclosed to a third party via this document or in another Release of Information form, will not be disclosed without my written consent.
- The Center for Valued Living, PLLC is legally mandated to disclose certain information, as it is not legally privileged. This includes reported or suspected child abuse, elder abuse, my intention harm myself, or my intention to harm others.
- Release of HIV-related information requires additional information and will not be disclosed unless authorized by me in writing.
- Depending on the provider's policies, there may be a charge for the requested records and that I will be responsible for said charges.

Signature of Client: _____ Date: _____

Relationship to Client (*if requester is not the client*): Parent Legal Guardian Other: _____

Reason client is unable to sign: Minor Deceased Gravely Disabled Other: _____

CVL rep signature: _____ (Lisa Michelle Griffiths, PsyD) Date: _____

Patient or Representative has been provided a copy of this authorization if requested:

Person providing copy