Mailing Address:
2620 S. Parker Rd., Suite 272
Aurora, CO 80014

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**

_____/_____ _____
Phone # / Fax # (Include area code) **City, State, Zip Code**

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

SPECIFIC INFORMATION AUTHORIZED: (select all that apply)
☐ **Assessment Reports** ☐ **Clinical Notes**
☐ **Diagnostic Impression** ☐ **Consultation Reports** ☐ **Treatment Summary/Plan** ☐ **Other: (**please describe)_

_____

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 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: _____

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: _____ Print name: _____ Date: _____