2620 S Parker Rd
Suite 185
Aurora, CO 80014
720-347-8559
720-207-6885
info@c4vl.com
www.c4vl.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City, State & Zip Code: _____

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: _____ Phone # (Include area code): _____ Fax # (Include area code): _____

Address: _____ City, State & Zip Code: _____

Email: _____

PURPOSE OF THIS REQUEST: (check one)

☐ Continued Healthcare

☐ Insurance
☐ Legal
☐ Personal
☐ Psychological Testing
☐ Social Security / Disability

☐ Workers Compensation
☐ 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
☐ Diagnostic Impression
☐ Consultation Reports
☐ Treatment Summary/Plan
☐ Other: (please describe) _____

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 or two years from this date maximum).
☐ One year from this date.
☐ Other: _____

Relationship to Client (if requester is not the client):

☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other: _____

Reason client is unable to sign:

☐ Minor ☐ Deceased ☐ Disabled ☐ Other: _____

_____ _____
Client Signature Date