Release of Information Consent Form

1. CLIENT INFORMATION

Client Full Name: _____

Client Date of Birth: _____

2. I AUTHORIZE

Courtney Dunson
Through the Trees Therapy LLC
Denver, CO
Phone: (720) 614-2339
Email: cj@throughtreestherapy.com

To: ☐ release information to ☐ obtain information from ☐ exchange information with the person/organization in section 3.

3. ORGANIZATION/INDIVIDUAL INFORMATION

Organization Name: _____

And/or Person Name: _____

Address: _____

City: _____ State: _____.

Zip: _____ Phone: _____

Email: _____

4. INFORMATION TO BE RELEASED

☐ Specific dates/years of treatment: _____

☐ All health information (excludes information from a chemical dependency program & psychotherapy notes)

OR indicate the specific categories to be released:

☐ Diagnosis ☐ Psychological Evaluations ☐ Discharge Summary

☐ Treatment Plans ☐ Social History ☐ Provider/Hospital Records School/Criminal

☐ Records ☐ Other: _____

5. PURPOSE FOR DISCLOSURE:

☐ Coordination of Care ☐ Legal/Court Order

☐ Personal Request ☐ Emergency Contact

☐ Other: _____

6. I UNDERSTAND THAT:

- My health information is protected by federal regulation (Alcohol & Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Through the Trees Therapy Privacy Notice.
- I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Through the Trees Therapy Privacy Notice outlines the procedure

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- for revocation. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.
- For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III))
- Communications resulting from this authorization will reveal that I receive services at Through the Trees Therapy.
- Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol & drug abuse patient records. However, HIPAA requires Ellie Mental Health to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA.
- This authorization may be used by Through the Trees Therapy owned or managed programs upon transfer of my care to them.

7. SIGNATURE

Patient's Signature: _____ Date: _____

OR Authorized Representative's Signature: _____ Date: _____

Representative's Name (printed): _____

Representative's Relationship to Patient: _____

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