DENVER WELLNESS ASSOCIATES
your path to well being

Denver Wellness Associates | Phone: 720-724-3668 | Fax: 720-598-0480 | Secure email: refill@denverwellness.com

HIPAA AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Please complete all sections. Incomplete forms cannot be accepted.

Section I: Client Information
I, _____ (client name), Date of Birth_____, authorize **Denver Wellness Associates** to ☐ **release** and/or ☐ **receive** the information listed in **Section II** with the person(s) or organization(s) named in **Section V.**

Section II: Information to be Shared
I authorize the release of the following health information (check one):
☐ My full health record, including but not limited to mental health diagnosis, treatment notes, billing, and appointment history.
☐ Only the following parts of my record (check any that apply):
☐ Mental health diagnoses and treatment ☐ Medication information ☐ Progress notes
☐Appointment history and billing ☐ Other (please specify): _____

Section III: Dates of Information to be Shared
This authorization is for the following dates (check one):
☐From _____to _____ ☐ All service dates

Section IV: Purpose for Sharing (Check one or write in your reason):
☐ At my request ☐ Coordination of care ☐ Legal/Court-related purposes ☐ Insurance ☐ Other: _____

Section V: Who May Release or Receive My Information
☐Release records to myself
☐ Name/Relationship/Organization *(if applicable)*: _____ Phone or email: _____
Fax *(if applicable)* _____ Address:_____
Note: The entities above may not be subject to HIPAA privacy laws and may re-disclose the information.

I understand that:
(1) If my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health information. **(2)** I do not need to give any further permission for the information detailed in **Section II** to be shared with the person(s) or organization(s) listed in **Section V**. **(3)** Failure to sign/submit this authorization or cancellation of this authorization will not prevent me from receiving treatment or benefits I am entitled to receive, provided this information is not required to determine eligibility for those treatments or benefits or to pay for the services I receive. **(4)** I may inspect or obtain a copy of the health information that I am being asked to disclose. **(5)** My signature on this form is strictly voluntary **(6)** I understand that I can revoke this authorization in writing at any time by completing a Revocation Form. **(7)** This authorization will remain in effect until satisfaction of the need for disclosure, for specified dates, or in 365 days from the date of signature unless I have provided revocation.

Section VI: Signature
Client Signature: _____Client Print Name: _____ Date:_____

If signing on behalf of the client (e.g., parent, legal guardian), please complete below:
Name of Person Signing: _____ Relationship: _____ Signature: _____
Date: _____ Legal Authority (e.g., parent, guardian, POA):_____