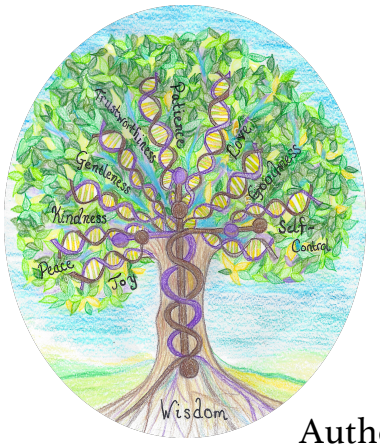

Abundant Living
Health Services
Serving Northern Colorado
(970) 699-6470
www.abundtantlivinghealthservices.com

Authorization for Release of Protected Health Information (PHI)

Patient Name: _____ DOB: _____ Phone: _____
I, _____, authorize, ***Abundant Living Health Services*** to **send/receive** the following records:

☐ Referral/treatment summary/update of progress in treatment
☐ Social, family, educational, and vocational history
☐ Academic/Educational records
☐ Admission/discharge summary
☐Other as listed below:
☐Psychological Evaluation
☐ Treatment Plan
☐ Psychoeducational Eval
☐ Psychotherapy Notes

(A separate authorization, as defined by HIPPA, is required for psychotherapy notes.)

to/from:

Provider: _____

Address: _____

Phone: _____ Fax: _____

This information will be used/disclosed for the following purposes:

☐Facilitate Continuity of Care
☐Complete and Evaluation
☐Other as specified:
☐Inform referral source of follow through for treatment
☐Legal matter concerning patient

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information) and applicable state laws. I further understand that the information disclosed may not be protected under these guidelines of the recipient is not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary and that I may revoke this consent at any time by providing written notice to Alicia Young, Ph.D.

I understand and agree that this Authorization is valid and in effect from the date of the signature and will automatically expire in one year.

I have discussed with my provider what information will be given, its purpose, and who will receive the information. I understand that I have the right to receive a copy of this authorization. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain services from *Abundant Living Health Services*, nor will it affect my eligibility for benefits.

I understand that I may inspect and have a copy of the information described in this authorization. There may be a cost for this copy or for other services.

I have read this form and/or had it explained to me and I understand its contents.

_____ _____ _____
Patient/Guardian Signature Relationship Date