Authorization to Release of Information

Name: _____

DOB: _____

_____ I authorize Natalie Teeters, MS True Life Counseling, TLC; 2204 18th Ave, Suite 126, Longmont, Co, 80501
To disclose and or obtain treatment information from the following:

Name: _____

Address: _____

_____

Phone: _____

Email: _____

Please sign below if you agree to release ALL of your Protected Health Information.
If you are limiting the information that is released, please list ONLY the information you agree to be released: By signing below I acknowledge that the above information about me may be released, discussed, or disclosed. I understand that my records are protected under Federal Regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for the regulations. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to my therapist. I understand that once information is disclosed as per my authorization, the recipient, in accordance with all applicable laws and regulations, may re-disclose the information and it might not be protected by federal or state privacy regulations.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____