RELEASE OF INFORMATION OR AUTHORIZATION

Client's Name _____ Client's DOB ____/____/_____

Family Member _____ Family Member _____

Address _____ Phone _____

City, State, Zip _____ Fax _____

I, _____, _____
Client's name or name of person authorizing this release of information — State legal authority to sign for client, if applicable

request information to be exchanged between **Trusted Therapy, Inc**, and the following:

☐ To
☐ From

Name of Director/Hospital/Person/Agency: _____

Address _____ Fax _____

City _____ State _____ ZIP _____ Phone _____

* *To check only one box to indicate the purpose for which information is to be released/authorized:* *

☐ Trusted Therapy, Inc "Treatment, Payment, or Operations" (specify purpose for this **Release**):
_____

☐ Other (specify purpose for **Authorization**): _____

I understand that, unless lined through or written in, information to be released/authorized may include information regarding the following condition(s):

- Drug Abuse
- Alcoholism or Alcohol Abuse
- Assessment, including Diagnosis
- Service Plans
- Other _____
- Psychiatric Conditions/Treatment/Psychological Testing
- HIV / Auto Immune Deficiency Syndrome (AIDS)
- Treatment Summary, Recommendations, Consultation
- Medical Information / Medications Prescribed

I understand that if this is a Release for "Treatment, Payment and/or Operations" purposes, Trusted Therapy, Inc may withhold treatment, payment, enrollment or eligibility for benefits if I refuse to sign.

I understand that if this is an Authorization for "Other" purposes, Trusted Therapy, Inc, may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign or not. However, Trusted Therapy, Inc may condition those things;

1) if the treatment is research-related treatment and the Authorization is needed to use or disclose protected health information for such research [this form has been so conditioned ____], or
2) for services conducted solely to produce information for a third party and the Authorization is for the disclosure of the protected health information to that third party {this form has been so conditioned ____}

* *This form has not been conditioned unless one of the two blanks has been checked.* *

- I understand that there is potential for information disclosed, as a result of this release/ authorization, to be redisclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulation.
- I understand that I may revoke this release/authorization at any time by giving written notice to Trusted Therapy, Inc, except to the extent that action has already been taken to comply with it. Without such revocation, this release/authorization will expire on __/__/__ (date), or if left blank, one year from the date of my signature, or as of the action or event of _____.
- I understand that I have a right to refuse to sign this Authorization Form subject to the conditions noted above or if I sign I am entitled to a copy of the signed form.

_____ _____ _____ _____
Signature of Client/Parent/Legal Representative — Date — Relationship to client — Date

_____ _____ _____ _____
Family Member — Date — Witness — Date

Notice to whom this information is given: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains. If applicable, a minimum necessary determination has been applied to this release/authorization. If you have questions concerning this release please call **303-709-5897**. Please send information to:

Trusted Therapy, Inc,1030, Suite323, Johnson Rd, Golden, CO 80401, Fax: 1-866-389-5337

* * * *Note: A facsimile copy is to be considered as valid as the original.* * * *

I hereby **revoke** this Release of Information or Authorization for Information:

_____ _____/_____/_____
Client Signature Revoking this Release or Authorization — Date