

**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 Mindful Health Advantage, LLC, and the following:

To

Name of Director/Hospital/Person/Agency: \_\_\_\_\_

From

Address \_\_\_\_\_ Fax \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone \_\_\_\_\_

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

Mindful Health Advantage, LLC "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
- Psychiatric Conditions/Treatment/Psychological Testing
- Alcoholism or Alcohol Abuse
- HIV / Auto Immune Deficiency Syndrome (AIDS)
- Assessment, including Diagnosis
- Treatment Summary, Recommendations, Consultation
- Service Plans
- Medical Information / Medications Prescribed
- Other \_\_\_\_\_

I understand that if this is a **Release** for "Treatment, Payment and/or Operations" purposes, Mindful Health Advantage, LLC 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, Mindful Health Advantage, LLC may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign or not. However, Mindful Health Advantage, LLC 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 Mindful Health Advantage, LLC, 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 **303-202-6143**. Please send information to:

**Mindful Health Advantage, LLC, 777 S. Wadsworth Blvd, Bldg 2, Ste 103, Lakewood, CO 80226;** or fax 303-202-6146

\* \* \* 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