

**Authorization to Disclose Protected Mental Health Information**

Cultivate Wellness Counseling, LLC

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720-500-5540

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I authorize Cultivate Wellness Counseling, LLC to use or disclose information from the above client's mental health record which may include information about psychiatric diagnosis and treatment to:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Fax: \_\_\_\_\_

Dates of treatment: \_\_\_\_\_

Information to be released: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Purpose of disclosure: \_\_\_\_\_

Authorization: I understand that, unless withdrawn, this authorization will expire one year from the date of the signature. A photocopy of this form will be considered as valid as the original. I understand that I may revoke this authorization at any time by notifying Cultivate Wellness Counseling, LLC at the email address indicated above and this authorization will cease to be effective on the date noticed except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state of federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment. My mental health care and payment for my mental health care at Cultivate Wellness Counseling, LLC will not be affected if I do not sign this form. By my signature, I consent to the release of information contained on this form for use by the requesting agency(cies). I understand that my records are protected under Federal and State regulations governing confidentiality, 42 part 2, HIPAA ,

and FERPA and cannot be released without my written consent unless otherwise provided for by the regulations. I acknowledge that I have been informed of my rights to refuse to sign this form, and any conditions related to my consent or refusal, and that I am entitled to receive a copy of the signed form

Signature: \_\_\_\_\_

Date: \_\_\_\_\_