Well Nourished LLC
Integrative Psychiatry
Wellnourishedpsych.com

Phone: (720) 513-1215
Fax: (720) 547-6960
Address: 12157 W Cedar Dr. Suite 200 Lakewood, CO 80228

Medical Records release

Patient Authorization for Disclosure of PHI (Protected Health Information)

Patient Name: _____
Patient Address: _____
Patient DOB: _____
Patient Phone: _____

_____ (initial) I give permission to Well Nourished LL and providers/staff within the practice to disclose my complete health record, including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse (excluding records subject to the Confidentiality of Alcohol and Drug Abuse Patient Records regulations at 42 CFR Part 2)), except for the following (complete, if applicable):
_____

To the following individuals: _____(Provider/Clinic/Person to receive PHI) at the following address/phone/email _____(Recipient's contact information).

Purpose of requested use or disclosure: Patient request.
This authorization will remain in effect until the termination of care at Well Nourished LLC I understand that I have the right to revoke this authorization, in writing, at any time, except where uses and disclosures have already been made based upon my original consent. I agree that revocation must be communicated in writing to Well Nourished LLC..

I understand that authorizing the disclosure of this information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria. I understand I am entitled to a copy of this document in its complete form. I understand that it is possible that information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient Name (printed) _____
Patient Signature: _____
Date:_____

Well Nourished LLC
Integrative Psychiatry
Wellnourishedpsych.com

Phone: (720) 513-1215
Fax: (720) 547-6960
Address: 12157 W Cedar Dr. Suite 200 Lakewood, CO 80228

If this form is being completed by a person with legal authority to act an individual's behalf as a Personal Representative in compliance with HIPAA, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form:_____
Signature of person completing this form: _____
Description of Personal Representative's Authority: _____