Center For Renewing Intimacy
6270 Lehman Drive, Suite 200 G
Colorado Springs CO 80918

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AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

I hereby authorize release of my confidential health information as described below. I understand this authorization is voluntary. I understand that if the organization(s) authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Client name: ___________________________________ Date of Birth: ___________________________________

Person providing the information:
Joann Condie (719) 331-6484
6270 Lehman Drive, Suite 200G
Colorado Springs CO 80918

Person/organization receiving the information:
____
____
____

Description of information to be disclosed: ____

____

The release of information is being made:

- ❒ At the request of the individual
- ❒ If at the request of another, explain the purpose of the request: ______________________________________

____

* This authorization will expire on ______/______/__________ (DD/MM/YYYY)

Carefully read the following statements before signing this authorization:

1. I may revoke this authorization at any time in writing, except as to information released before receipt of the revocation.
2. I understand that my health care will not be denied if I refuse to sign this authorization.
3. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections.
4. I am entitled to a copy of this authorization.

____ ___________________________________

* Signature of Client Date

Printed name of Client's representative: ____

____ __________________________

* Signature of Client's representative Date

Representative's authority to act on behalf of the Client. ______________________________________

____

*** Expiration date must be specified * Form must be completed before signing**

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION