TEOCALLI TREATMENT OPTIONS, LLC

123 W. Tomichi Ave., Suite 6, Gunnison, CO 81230

Heather C. Peterson, MA, LAC

RELEASE AND RETRIEVAL OF MENTAL HEALTH INFORMATION

CLIENT/PATIENT:

_____ _____

Name of Patient/Previous Names | Street Address

_____ _____

Birth Date | City, State, Zip

AUTHORIZES:

Heather C. Peterson, MA, LAC
Teocalli Treatment Options, LLC
123 W. Tomichi Ave. Suite 6
Gunnison CO, 81230
(970) 641-3711

Name & Address of Health Care Provider

RELEASE OF PROTECTED HEALTH INFORMATION TO:

_____

Name & Address of Health Care Provider/Plan/Other

INFORMATION TO BE RELEASED MAY INCLUDE THE FOLLOWING: (initial all applicable)

____ Assessment and Diagnosis
____ Evaluation or Testing Results
____ Medication Assessments/Regimen
____ HIV/AIDS Information
____ Substance Abuse Information
____ Social History, Background
____ Medical/Lab Information
____ Updates/Discharge Summary
____ Treatment Progress
____ Education Info
____ Legal Information
____ Other (Specify):_____

PURPOSE FOR NEED OF DISCLOSURE: (initial all applicable)

____ Assessment
____ Continuity of Care
____ Treatment Payment, Operations
____ Evaluation Purposes
____ Coordination of Care
____ Professional Consultation
____ Service Planning
____ Report to Courts or Other Agencies
____ Other (Specify):_____

*I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by asking Heather C. Peterson, MA, LAC, Teocalli Treatment Options, LLC. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Heather C. Peterson, MA, LAC, Teocalli Treatment Options, LLC. I am aware that my withdrawal is not retroactive and therefore, will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____OR if left blank, six months following termination of treatment with Heather C. Peterson, MA, LAC, Teocalli Treatment Options, LLC.

I have had an opportunity to review and understand the content of this authorization form. By initialing below and signing this authorization, I am confirming that it accurately reflects my wishes. Initials _____

_____ _____

Client/Parent/Guardian Signature Date Witness Signature Date

I am revoking consent and authorization to request or release information.

_____ _____

Client/Parent/Guardian Signature Date