

TEOCALLI TREATMENT OPTIONS, LLC

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

Heather C. Peterson, MA, LAC

EMAIL AND INTERNET RELEASE OF INFORMATION

Client Name: _____ **Date:** _____

I hereby authorize Heather C. Peterson, MA, LAC, Teocalli Treatment Options, LLC and:

(List yourself here if this release is for internet communications between you and your provider)

to release information from my record to each other via email or over internet-based communication devices (such as “Skype”) for the following purpose/s:

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

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

PURPOSE FOR NEED OF DISCLOSURE: (initial all applicable)

- | | | |
|-------------------------------------|----------------------------|--|
| _____ Assessment | _____ Evaluation Purposes | _____ Professional Consultation |
| _____ Continuity of Care | _____ Coordination of Care | _____ Service Planning |
| _____ Treatment Payment, Operations | | _____ 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