**DEBBIE BURMEISTER, LPC, RPT-S**

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**Authorization to Disclose Protected Mental Health Information**

Patient Name: SSN:

Address: Birth Date:

Telephone:

|  |  |
| --- | --- |
| Health Care Information From: | Release to: |

I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, and drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

I authorize the above named health care provider to disclose the privileged information specified below to the organization, agency, or individual named on this request:

**INFORMATION REQUESTED:**

Place/Date of Service:

Kind and amount of information to be disclosed:

Purpose of disclosure/why information required:

**AUTHORIZATION:** I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I mat revoke the authorization at any time in writing by sending a letter to the facility privacy officer or their designee and that it will expire at the end of litigation involving me. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. **This authorization expires six months form the date of patient’s or representative’s signature below, unless otherwise specified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.** If I have authorized disclose of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be valid as the original.

I understand that:

1. Authorization disclosure of health information is voluntary.
2. I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility to obtain benefits.
3. I may inspect or obtain a copy of the information to be disclosed.
4. A fee will be charged for any copy of my health record.
5. The facility will provide me a copy of the signed authorization form.

If I have questions about disclosure of my health information, I can contact the facility privacy officer or their designee.

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

Patient (Parent or Guardian if patient is a minor)

Minor’s signature is required for release of any records for treatment that the minor may have authorized.

RELATIONSHIP (if other than patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IDENTIFICATION OF PATIENT OR DESIGNATED REPRESENTATIVE

\_\_ Driver’s License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Passport #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ State ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Other ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_