Rocky Mountain Center for Development, LLC
2305 E Arapahoe Rd, Suite 250, Centennial, CO 80122
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www.RMCDTherapies.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient:____ DOB:_______________

Regarding the above named Patient, I____________________________ authorize any and all employees/contractors at Rocky Mountain Center for Development at the above listed address to release______________ exchange__________ protected health and/or educational information with:

____
(name of person/facility and address to receive information)

Please specify the health information you authorize to be released:
Medical___________ Mental Health__________ Educational_________ Other____________
Type(s) of health information:________________________
Date(s) of treatment:______________________________

The following information will not be released unless you specifically authorize it by checking the relevant spaces below:

- I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis, or treatment.__________
- I specifically authorize the release of HIV/AIDS test results.__________
- I specifically authorize the release of any and all material records (ie copies of records) from third party entities________

The purpose of this release is (check one or more):
At the request of patient/guardian._______________ Other (state reason):_____________

NOTICE
Rocky Mountain Center for Development, LLC, and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS
This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except in the following cases: (1) To conduct research-related treatments, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to Rocky Mountain Center For Development, LLC. You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires on ________________ (insert applicable date or event). If no date is indicated, the Authorization will expire 12 months from date of signing this form.

Printed Name of Patient/Guardian:____
Signature of Patient/Guardian:__________________________________ Date_______________