Cottonwood Creek Wellness Center

Authorization for Use or Disclosure of Protected Health Information

In order for us to provide maximally beneficial service to our clients, it is often necessary to communicate with other people or agencies with whom you have or have had contact. Your signature on this form gives us, Cottonwood Creek Wellness Center, permission to contact the person(s) or agency named below and to share or obtain the information for which you have authorized release. Any other sharing of information gained during our contacts is expressly prohibited except in situations where disclosure is ethically or legally required. If you agree, please complete this form.

I, ______________________ ______________________ hereby authorize Cottonwood Creek Wellness to:
First name Last name

☐ Release ☐ Obtain ☐ Exchange

The following information:

- ☐ Complete Record
- ☐ Medical Records
- ☐ Psychological Assessment Reports
- ☐ Progress Notes
- ☐ Intake Summary
- ☐ Personal Assessment
- ☐ Treatment Plan
- ☐ Treatment Summary
- ☐ Confirmation of and Dates of Services
- ☐ DSM-V diagnosis
- ☐ Medical diagnosis
- ☐ Other (list) ______________________

To or From:

Name:____
Address:____
City:___________________ State:______ Zip: ___________
Telephone: ____
Fax: ____

For the Purpose Of:

□ Ongoing Medical Care
□ The client has requested this information be used and disclosed but does not wish to specify the purpose.
□ Other (List):____

This authorization shall be in effect for one year to the date of the client's signature. At this time, the authorization to use or disclose this protected health information expires.

Date Authorization Expires (if different from one year to date of signature):
____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

Cottonwood Creek Wellness Center
3210 E. Woodmen Rd., #110
Colorado Springs, CO, 80920

________________________________ ____________________________________
Client Signature Printed Name

Date: ____/____/______

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Signature of Therapist