Inner Life Adventures, LLC
343 West Drake Road Suite 270
Fort Collins, CO 80526
970-829-0478
970-616-6699 fax

CONSENT FOR RELEASE AND/OR RETRIEVE OF INFORMATION

Client's Name: _____ Date of Birth: _____

Purpose: [ ] Professional Collaboration [ ] Treatment Planning [ ] Diagnosis/Evaluation [ ] Billing/Financial [ ] Medication [ ] Family/Support Collaboration [ ] Other: _____

I hereby consent to Inner Life Adventures, LLC to [ ] Exchange [ ] Release [ ] Receive verbal and/or written information regarding the above client to/from:

Name of person and/or organization:_____

Address:_____

Phone: _____ Fax: _____ Email: _____

I wish to release: [ ] All relevant information [ ] Confirmation and dates of sessions [ ] Initial Evaluation [ ] Diagnosis [ ] Written summary of treatment [ ] Financial/Billing Information (may include dates and services)

[ ] Other: _____

Limitations, if applicable: _____

AUTHORIZATION: I authorize the use or disclosure of my protected health information as described above. I understand this authorization is voluntary. I understand that if the person/entity authorized to receive information is not a health care provider, then the released information may no longer be protected by Federal privacy regulations.

I understand that I may revoke this authorization at any time by giving written notice except in the extent that action has already been taken on this request. This authorization will expire one year from the date treatment is terminated unless a written request to revoke authorization is received.

_____ _____ _____

Name of Client (or Guardian) Signature of Client (or Guardian) Date