# RELEASE OF INFORMATION

Client's Name _____ Client's DOB ____/____/_____

Family Member _____ Family Member _____

Address _____ Phone _____

City, State, Zip _____ Fax _____

I, _____, _____
Client's name or name of person authorizing this release of information — State legal authority to sign for client, if applicable

request Protected Health Information to be exchanged between **Mindful Health Advantage, LLC**, and the following:

☐ To
☐ and / or From

Name of /Person/Agency: _____

Address _____ Fax _____

City _____ State _____ ZIP _____ Phone _____

Specify purpose for this Release**:** "Treatment, Payment, and/or Operations"

_____

I understand that, unless lined through or written in, information to be released/authorized may include information regarding the following condition(s):

- Drug Abuse
- Alcoholism or Alcohol Abuse
- Assessment, including Diagnosis
- Service Plans
- Other _____
- Psychiatric Conditions/Treatment/Psychological Testing
- HIV / Auto Immune Deficiency Syndrome (AIDS)
- Treatment Summary, Recommendations, Consultation
- Medical Information / Medications Prescribed

I understand that this is a Release for "Treatment, Payment and/or Operations" purposes, and Mindful Health Advantage, LLC may withhold treatment, payment, enrollment or eligibility for benefits if I refuse to sign.

- I understand that there is potential for information disclosed, as a result of this Release, to be redisclosed by the recipient, and therefore no longer protected by the HIPAA Privacy Regulation.
- I understand that I may revoke this Release at any time by giving written notice to Mindful Health Advantage, LLC, except to the extent that action has already been taken to comply with it. Without such revocation, this Release will expire on ___/___/___ (date), or if left blank, one year from the date of my signature, or as of the action or event of _____.
- I understand that I have a right to refuse to sign this Release of Information Form subject to the conditions noted above, or if I sign I am entitled to a copy of the signed form.

X _____ _____ _____ _____
Signature of Client/Parent/Legal Representative — Date — Relationship to client — Date

_____ _____ _____ _____
Family Member — Date — Witness — Date

*Notice to whom this information is given:* This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains. If applicable, a minimum necessary determination has been applied to this release/authorization. If you have questions concerning this release please call **303-202-6143**.

Please send information to:

**Mindful Health Advantage**, LLC, **12136 W. Bayaud Ave., Ste 140, Lakewood, CO 80228;** or fax **303-202-6146**

* * * ***Note: A facsimile copy is to be considered as valid as the original.*** * * *

I hereby **revoke** this Release of Information:

_____ _____/_____/_____
Client Signature Revoking this Release — Date