Well Nourished LLC
Integrative Psychiatry
Wellnourishedpsych.com

Phone: (720) 513-1215
Fax: (720) 547-6960
Address: 12157 W Cedar Dr. Suite 200 Lakewood, CO 80228

Release of Information

Authorization for Use and Disclosure of Protected Health Information (Required by Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164).

1. Authorization. I hereby request and authorize WELL NOURISHED, LLC to use and disclose the protected health information described below to the provider information below.
2. Effective Period. This authorization for release of information covers all past, present and future periods of health care.
3. Extent of Authorization. I authorize the release of my complete health record (including records related to mental health care, communicable disease and the treatment of alcohol or substance abuse).
4. Use. The medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes that I can direct.
5. Termination. This authorization will be in force and effect until the Death of the Patient, at which time this authorization form expires.
6. Revocation Rights. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining health insurance coverage and the insurer has a legal right to contest a claim.
7. Disclosure. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Provider/Individual Name: _____

Provider/Individual Phone Number: _____

Provider/Individual Address: _____

- ☐ Information to be disclosed:
- ☐ Entire Record
- ☐ Treatment Plan
- ☐ Appointment Dates
- ☐ Billing
- ☐ Other _____

By signing this consent, THE PATIENT OR GUARDIAN AGREES to and endorses understanding of this policy.

_____ _____
Signature Date