behavioral
medicine center

phone 303.830.1181
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www.behavioralmedicinectr.com

Authorization for Release of Information

NAME:_____DOB:_____SSN:___XXX-XX-_____

By signing this form, I, _____authorize Rebecca Hawkins, Ph.D., PC (DBA Behavioral Medicine Center) to release and/or receive:

_____ **Protected Health Information** (written and/or verbal communication)

_____ **Psychological/Neuropsychological Evaluation(s)** (written and/or verbal report)

_____ **Other specified information:**_____

To and/or from the following person(s) or agency(s):

_____ My insurance carrier(s):_____, including representatives thereof (e.g., nurse/medical case manager, claims adjustor, legal counsel, third party administrator, etc.), and the Division of Workers' Compensation (WC; if applicable) for the purpose of verifying benefits, obtaining authorization and payment, and/or other relevant health care operations.

_____ My referring/treating medical provider(s):_____

_____for continuity of care.

_____ My attorney(s):_____as per my request.

_____ Other: (_____)_____

for the purpose of _____

_____ Other: (_____)_____

for the purpose of _____

This authorization shall remain in effect until closure of the WC claim for which I have been referred to the Behavioral Medicine Center, or one year from the date below (whichever is later). If not seen through WC, this authorization will expire one year from the date below. I understand that I have the right to revoke this authorization at any time by sending written notification stating my request of revocation. I also understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information, and therefore will no longer be protected by the HIPAA Privacy Rule. Furthermore, I understand that my provider generally may not condition psychological services upon my signing an authorization, unless the services are provided to me for the purpose of creating health information for a third party. Last, a photocopy of this authorization shall be as valid as the original.

_____ _____

Signature of Patient Date

1776 South Jackson Street, Suite 901-5, Denver, CO 80210-3808