Authorization for Disclosure of Protected Health Information &
Request for Confidential Communication

Heartfelt Healing, LLC, 2201 Kipling Street, Ste. 204, Lakewood, CO 80215
Barbara (Tia) Amdurer, (LPC.0012480 - Colorado)

I, _____ hereby authorize Barbara (Tia) Amdurer, LPC
(Name of Client and Authorized Parent or Guardian of Minor if applicable)

(DBA Heartfelt Healing, LLC) and _____
Name of other mental health or medical professional

_____
(Agency Name if applicable) Address Phone

To □ release and/or □ receive the following information: (Check all that apply)

□ Summary of Progress □ Evaluation/Assessment □ Acknowledgement of service
□ Termination Summary □ Attendance/Participation/Progress
□ Other: _____

For the purpose of:
□ Treatment □ Referral □ Billing
□ Other: _____

Periods of treatment:
□ All Treatment Episodes □ Current Treatment Episode

□ Specific Treatment Episode: Begin Date: _____ End Date: _____

Regarding _____ **DOB** _____
(Name of Client/Minor)

I understand that my records or those of the individual listed above are protected under state and federal mental health confidentially regulations including 42CFR Part 2. Information cannot be disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand and agree that this release form may be sent to the agencies and persons identified above. Copies of this form may be used in lieu of the original.

I understand that the disclosure of health information is voluntary and I have the right to refuse to sign this authorization. I understand there is potential for information disclosed as a result of this release/authorization to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken based upon it by providing written notice to the provider's address on this form. Unless the purpose of this authorization is to determine payment of a claim or benefits, my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. This consent expires and cannot be used past the indicated date or event.

Expiration Date or Event: _____
(Not more than one year)

X _____ _____
SIGNATURE OF CLIENT OR AUTHORIZED PARENT OR GUARDIAN OF MINOR NAMED HEREIN DATE

Consent Revoked DATE: _____

_____
SIGNATURE OF AUTHORIZED PARENT OR GUARDIAN OF MINOR NAMED HEREIN