Tennyson Center for Children
CHANGING LIVES. GIVING HOPE.

2950 Tennyson Street, Denver, CO 80212
303-433-2541 | Fax: 303-433-9701

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Information

Full Name: ____

DOB: ______________________________

Full Address: ____

Phone #: _______________________________

I hereby authorize Tennyson Center for Children to Receive From and Release To, Personal Health Information:

____
Name / Title of Organization

____
Full Address

____
Contact Phone Number and Email

Purpose & PHI Disclosed

☐ Continuation of Care ☐ Insurance / Legal ☐ At request of parent/guardian
☐ Other: ____

For Treatment Dates: ____

☐ All health records and testing results including medical history and immunizations
☐ Educational Assessments / IEPs ☐ Staffing / Progress Notes ☐ Psychological Reports
☐ Treatment Information ☐ Occupational Therapy Record
☐ Other: ____

Authorization

______ By initialing this area, I authorize the release of the above-named client's health records that may include information indicating the presence of communicable or venereal diseases, which may include, but are not limited to infectious diseases and AIDS/HIV.

______ By initialing this area, I authorize the release of the above-named client's health records that includes information about behavioral and/or mental health services and/or treatments.

- This request is made voluntarily and the information given is accurate to the best of my knowledge.
- I may revoke this authorization at any time in writing, but if I do, it will have no effect on actions taken prior to receiving the revocation.
- I understand that information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and is no longer protected by the HIPAA privacy rule.
- Without my express revocation, this consent will automatically expire 180 days from the date signed below, unless I request an expiration date less than 180 days.

Signature

My signature is required to validate this Authorization. If I sign this form, the above-named client, their payment for health care services, and their ability to enroll for benefits will not be affected.

_______________________________________ _______________ _____________________________
Client's Authorized Representative Signature *Date* *Relationship to Client*

_______________________________________ _______________ _____________________________
Client's Authorized Representative Signature *Date* *Relationship to Client*