Dr. Caitlin O'Connor
2530 W. 29th Ave
Denver, CO 80211
Phone: 720-855-3160
Fax: 720-855-3660

Release of Information or Authorization

I authorize Dr. Caitlin O'Connor, ND to release and receive the information indicated to the agency or persons listed below for purposes of service coordination, continuity of care, and case management.

Patient Name:_____ Date of Birth: _____

Information to be released (please check all appropriate)

- ○ All medical and mental health treatment records which includes mental health condition and treatment
- ○ Verbal communications, including communications either verbally or written
- ○ Drug abuse or alcohol abuse, which includes, if any, alcohol or substance abuse condition and treatment
- ○ Other:_____

Information to be released to and from:

Agency or Person	Address	Phone/ Fax

Release of Information or Authorization

- I understand that my records and/or those of any individuals listed above are protected under state and federal confidentiality regulations. I understand that if I have authorized the release of drug abuse and/or alcohol abuse information that the confidentiality of this information is protected by Federal Law [42 CFR, Part 2]
- This information cannot be disclosed without my written consent, unless otherwise specifically provided for in the regulations.
- I understand that I may revoke this consent at any time.
- Copies of this form may be used in lieu of the original.
- I understand and agree that this release form may be sent to the agencies and persons identified above.
- I understand that there is potential for information to be 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.

_____

Signature Print Name Date

If not Patient, please print and state your legal authority to sign for Patient/Client: