INTEGRATED WELLNESS AND STRATEGIES, LLC
Amber W. Pearson, MA, LPC, LCMHC, LMHC, EMDR-CT
Your path to healing and transformational growth...

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AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT INFORMATION

Full Name: _____ Date of Birth: _____

Gender Identification: ☐ Male ☐ Female Other: _____

RELEASE INFORMATION

Name of Agency/Organization/Individual: _____

Relationship to Client: _____ Fax Number: _____

Address: _____

City:_____ State: _____ Zip: _____

Primary Phone Number: _____ Alternative Phone Number: _____
Ok to leave a voicemail? ☐ Yes ☐ No Ok to leave a voicemail? ☐ Yes ☐ No

I agree that Amber W. Pearson, MA, LPC of Integrated Wellness & Strategies, LLC may *OBTAIN INFORMATION FROM* the above organization or individual as follows: ☐ Verbal Only OR ☐ Verbal & Written

Request Dates: _____to_____ .
Note: If end date is left blank, this form will expire within one year from the date of signature.

For medical facilities and/or hospitals: ☐ Recent Admission ☐ All Admissions ☐ N/A

Purpose of correspondence may only occur as follows:

- ☐ Emergency Contact
- ☐ Information pertinent to coordinating care
- ☐ Continuity of Care
- ☐ Service/Treatment Plan
- ☐ Medication History/Orders
- ☐ Psychological Evaluation Report
- ☐ Psychiatric/Multidisciplinary Assessment
- ☐ Physician Summaries
- ☐ Clinical Notes
- ☐ Laboratory Data/Results
- ☐ Medical History Questionnaire
- ☐ Clinical Progress Summaries
- ☐ Discharge Summary
- ☐ Diagnostic Summary
- ☐ Records
- ☐ Plans
- ☐ Testing
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

I agree that Amber W. Pearson, MA, LPC of Integrated Wellness & Strategies, LLC may *RELEASE INFORMATION TO* the above organization or individual as follows: ☐ Verbal Only OR ☐ Verbal & Written

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☐ Diagnostic Summary
☐ Records
☐ Plans
☐ Other:_____
☐ Other:_____
☐ Other:_____
☐ Other:_____

INITIALS AND SIGNATURE

By signing below I agree to the above release(s) and I understand that:

- It is possible that redisclosure may occur by the recipient of this form.
- I may revoke this release/authorization at any time, by written notice or signing the box below. If this release/authorization is revoked, action will be taken on the part of Amber W. Pearson, MA, LPC and Integrated Wellness and Strategies, LLC to comply *after* notice or revoking of signature occurs.
- The information being requested/released may include, but is not limited to, any of the following conditions protected by law: Psychological/Psychiatric, HIV/AIDS, Sickle Cell Anemia, Alcohol/Drug Abuse and/or Dependence/Treatment. If any of these conditions are shared it will be handled according to State and Federal confidentiality standards.
- I understand that this form is compliant with HIPAA regulations and no medical or no psychotherapeutic information, or other information related to my privacy, will be released without permission unless mandated by Colorado law. Consistent with HIPAA guidelines authorization for release and consent for treatment will be automatically revoked one year after the signing date.

I understand that this consent will expire on: _____.

Note: If date is left blank, this form will expire within one year from the date of signature.

Client Name (printed) Client Signature Date

REVOKE: I hereby revoke this Release of Information.

Client Name (printed) Client Signature Date