



INTEGRATED WELLNESS AND STRATEGIES, LLC

Amber W. Pearson, MA, LPC

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 Plan
- Medication History/Orders
- Psychological Evaluation Report
- Psychiatric/Multidisciplinary Assessment
- Physician Summaries
- Nurse Notes
- Laboratory Data/Results

- Medical History Questionnaire
- Clinical Progress Summaries
- Discharge Summary
- Service Plan
- Education Testing
- Education Records
- Education Plans
- Social Services Tx Plan
- 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

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:

- | | |
|---|--|
| <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Medical History Questionnaire |
| <input type="checkbox"/> Information pertinent to coordinating care | <input type="checkbox"/> Clinical Progress Summaries |
| <input type="checkbox"/> Continuity of Care | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Service Plan | <input type="checkbox"/> Service Plan |
| <input type="checkbox"/> Medication History/Orders | <input type="checkbox"/> Education Testing |
| <input type="checkbox"/> Psychological Evaluation Report | <input type="checkbox"/> Education Records |
| <input type="checkbox"/> Psychiatric/Multidisciplinary Assessment | <input type="checkbox"/> Education Plans |
| <input type="checkbox"/> Physician Summaries | <input type="checkbox"/> Social Services Tx Plan |
| <input type="checkbox"/> Nurse Notes | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Laboratory Data/Results | <input type="checkbox"/> 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
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REVOKE: I hereby revoke this Release of Information.		
_____	_____	_____
Client Name (printed)	Client Signature	Date

Copy provided to client.