INTEGRATED WELLNESS AND STRATEGIES, LLC
Amber W. Pearson, MA, LPC
Your path to healing and transformational growth...
11001 W. 120th Ave, Suite 400
Broomfield, CO 80021
P: 720-644-6378, F: 720-446-3520
strategiesintegrated.com

EMERGENCY CONTACT - RELEASE OF INFORMATION

Client Full Name: _____ Date of Birth: _____

Gender Identification: ☐ Male ☐ Female ☐ Other: _____

In case of an emergency, please fill out information on whom Amber W. Pearson, MA, LPC should contact:

Name:_____ Relationship To Client:_____

Contact Phone 1:_____ Contact Phone 2:_____

Ok to leave a voicemail? ☐ Yes ☐ No Ok to leave a voicemail? ☐ Yes ☐ No

Street Address:_____

City:_____ State:_____ Zip:_____

I agree that Amber W. Pearson, MA, LPC of Integrated Wellness & Strategies, LLC may *OBTAIN INFORMATION FROM* and *RELEASE INFORMATION TO* the above individual verbally. The purpose of correspondence may *only* occur as follows:

☐ Emergency Purposes ☐ Other:_____

If Amber W. Pearson, MA, LPC is concerned for your well-being, and/or you are in crisis, by signing below, I give Amber W. Pearson, MA, LPC permission to contact this person in order to verify and/or ensure my safety. In addition, by signing below I agree to the above release(s) and I understand that:

- It is possible that re-disclosure 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

☐ Copy provided to client.