The Neurofeedback Clinic of Northern Colorado

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

RELEASE OF INFORMATION OR AUTHORIZATION

I authorize the Neurofeedback Clinic of Northern Colorado (**NCNOCO**) to ☐ release or ☐ receive the information indicated to the agency or persons listed below for the purpose of service coordination, continuity of care, and case management.

This authorization pertains to:_____ _____
Print Name Date of Birth

Information to be released or requested: (Check every box applicable)

☐ All medical and mental health treatment records which include mental health condition and treatment, for all dates of treatment: Including but not limited to ☐ clinical charts, ☐ office notes, ☐ test reports, ☐ test data, ☐ physician notes, ☐ note of progress to date, ☐ consultation reports and notes, ☐ outpatient records, ☐ correspondence related to clinical matters, and ☐ mental health diagnosis.

☐ Verbal communications: Including communication either verbally or in writing with the person(s) or entity(ies) listed below, regarding all the released information available, including information contained in treatment records as described above, and is authorized to give opinions and answer questions.

☐ Drug abuse or alcohol abuse which includes, if any, alcohol and substance abuse condition and treatment information. Includes all information regarding any assessments, diagnosis, referral, history, or discussion of drug abuse or alcohol abuse.

☐ Other:

Information to be released to or from:

Name of agency or person	Address/Telephone
_____	_____
_____	_____
_____	_____

- I understand that my records and/or those of any individual(s) listed above are protected under Federal and State 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.
- This disclosure is at the request of the individual or legal authority or _____ . This disclosure is for the purpose of ☐ Treatment, ☐ Payment, ☐ Operations, or ☐ Other. If "Other" is checked, regardless of whether additional purposes are also checked this form is a HIPPA compliant Authorization. Also if this is an Authorization, NCNOCO must provide you with a copy.
- I understand that there is a potential for information disclosed as a result of this release/authorization to be re-disclosed by the recipient and therefore no longer be protected by the HIPPA Privacy regulations.
- This consent expires and cannot be used past the following date: (Not to exceed two (2) years)

_____ _____
Signature Date

_____ _____
If not the client, please print and state your legal authority to sign for the client Date

_____ _____
Witness signature Date

I Hereby revoke this consent to Release/Authorize for Information.

_____ _____ _____ _____
Client Signature Date Witness Signature Date

Revised 07/01/2016