DENVER DIABETES COUNSELING

Jenna Eisenberg, LMFT
5650 Greenwood Plaza Blvd, Ste 225K
Greenwood Village, CO 80111
720-420-6541
www.denverdiabetescounseling.com

Authorization for Release of Information

Client Name:
Date of Birth:
Phone:
Address:

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with Colorado State Law and the Privacy Rule of Health Insurance Portability and Accountability act of 1996 (HIPAA), I understand that:

*This authorization may include the disclosure of information relating to Alcohol and Drug Abuse, Mental Health Treatment, except psychotherapy notes, child abuse, communicable diseases, artificial insemination, HIV/AIDS related information, genetic testing, cancer and sexually transmitted diseases only if I place my initials on the pertinent items on this form.

*I understand that I have the right to revoke this authorization at any time by providing a written request to the provider. I understand that this authorization expires annually or based on timeline listed below.

This authorization does not authorize you to discuss my information or care with anyone other than the parties listed below:

Name and address of Provider to release this information:
Jenna Eisenberg, LMFT
Denver Diabetes Counseling
5650 Greenwood Plaza Blvd. #225K
Greenwood Village, CO 80111

Name and address of person(s) or agency to whom this information will be sent:

Specific Information to be Released:

- Psychotherapy Records, including client history (mental and physical), referrals, consults and a general summary of treatment goals **(Psychotherapy notes will <u>not</u> be provided)** _____
- Alcohol Drug Treatment _____
- Mental Health Information _____
- Mental Health Diagnosis _____
- Treatment Planning _____
- Treatment Progress _____
- Prescription Medication Information _____
- HIV-Related Information _____
- Child Abuse _____
- Sexually Transmitted Diseases _____
- Communicable Diseases _____
- Alzheimer's _____
- Other _____

By initialing here_____, I authorize_____ to discuss my mental and physical
(Initials) (Name of individual/agency)
health information with the persons listed here:
Jenna Eisenberg, LMFT and Denver Diabetes Counseling_____
(Name of provider or agency)

Dates or Event on Which Authorization will Expire:

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If not the client, name of person signing form:	***Relationship to Client/Authority to Sign on Behalf of Client:***

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form if requested.

_____ _____
Signature of Client or Client Representative Date

_____ _____
Signature of Client or Client Representative Date

_____ _____
Signature of Provider/Therapist (witness) Date