Denver Biofeedback Clinic, Inc.

Phone 720-855-6680 Fax 303-433-1899

RELEASE OF PROTECTED HEALTH INFORMATION AND VERBAL COMMUNICATIONS DISCLOSURE

I, ____, hereby authorize Denver Biofeedback Clinic, Inc. and its agents to release protected health information related to my evaluation and / or treatment to my insurance company and / or treating physician(s). I also authorize the individuals, professionals, and companies named below to communicate with and / or release information to Denver Biofeedback Clinic, Inc.

This disclosure is for the purpose of ____ Treatment, _____ Payment, ______ Operations, ______ the release of Psychotherapy Notes, or _______ Other. If "the release of Psychotherapy Notes or Other" is checked, regardless of whether additional purposes are also checked, this form is a HIPAA compliant Authorization. As such, Denver Biofeedback Clinic, Inc. may not condition treatment, payment, enrollment in a health plan, or eligibility for health plan benefits on your signing this Authorization. Also, if this is an authorization, the practitioner must provide you a copy.

Insurance name: ____
Address: ____
Phone: ______________________ Fax: ______________________

Referring physician: ____
Address: ____
Phone: ______________________ Fax: ______________________

Attorney: ____
Phone: ______________________ Fax: ______________________

Other: (Physical Therapists, Psychologists, etc.) ***** Please give a phone number for each name listed.**

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THIS DISCLOSURE is intended to cover any and all medical records including but not limited to, those regarding drug and alcohol abuse, psychological or psychiatric disorders, muscle injuries or disorders, nerve injuries or disorders, bone or joint injuries and disorders, and brain injuries and disorders.

Denver Biofeedback Clinic, Inc. and its agents, as well as others named above, are AUTHORIZED to verbally communicate with my insurance company and physician(s) and each other concerning the information contained in the medial records and regarding my treatment and evaluation. It is not necessary that I be present during any such conversations. This authorization does not include anyone other than my biofeedback therapist or their agents, and those named above.

I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will expire 1 year after the date of signature below. I may revoke this authorization with written notice, except to the extent that the practitioner or Denver Biofeedback Clinic, Inc. has taken action. You may treat a photocopy or fax of this signed authorization as a duly executed original for all purposes.

DATED this ________ day of _____________, 200___.

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Signature of Patient

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Signature of Therapist