PRE-EMPTIVE DENIAL OF RELEASE
of
HIPAA-PROTECTED HEALTH INFORMATION

TAKE TWO HEALTH
2503 Walnut St #200
Boulder CO 80302
www.taketwohealth.com
tel: 303-557-2250
fax: 303-325-7688

TO: _____
Party to whom Information is Denied

_____
Relationship (or other Identifier)

_____
Street Address (if known)

_____
City, State and ZIP (if known)

_____
Telephone (if known)

_____
Fax (if known)

_____
email (if known)

REGARDING: _____
Patient Name

_____
Date of Birth

_____
Street Address (or "REDACTED")

_____
City, State and ZIP (or "REDACTED")

_____
Telephone (or "REDACTED")

_____
Fax (or "REDACTED")

_____
email (or "REDACTED")

TAKE TWO HEALTH takes my privacy and my right to make choices in my life very seriously.

Sometimes, a person may make a choice in life to restrict communication with, or information to, someone whom the law may generally assume to be an "interested party" (such as a legal spouse, a blood relative, or someone who is financially involved in a person's life or care, etc).

With this document, I am hereby pre-emptively **DENYING** any access to information about me to the above-designated party. Should **TAKE TWO HEALTH** ever receive a request for information about be from said party, they are to **RELEASE NO INFORMATION.**

I hereby formally direct and instruct **TAKE TWO HEALTH** to **DENY ACCESS** to any information about me, should **TAKE TWO HEALTH** ever receive a request for information about me from the above-referenced party or their representative(s).

By design, neither this document nor **TAKE TWO HEALTH** shall state any reason for my denial.

This denial shall remain in effect in perpetuity, unless specifically revoked by me in writing, or by the order of a Court of competent jurisdiction. It cannot be revoked by my legal representative or Healthcare Power of Attorney if I am incapacitated, deceased or otherwise unable to represent my own wishes.

_____ _____
Signature of Patient Date

_____
Printed Name