AUTHORIZATION FOR COMMUNICATION ABOUT YOUR HEALTH including 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:

_____
Practitioner, Advocate or Support Person

_____
Facility / Agency (if any)

_____
Street Address

_____
City, State and ZIP

_____
Telephone

_____
Fax

_____
email

REGARDING:

_____
Patient Name

_____
Date of Birth

_____
Street Address

_____
City, State and ZIP

_____
Telephone

_____
Fax

_____
email

I authorize, request and direct the above-designated party to COMMUNICATE about my health with:

Leto Quarles MD
TAKE TWO HEALTH
2503 Walnut Street #200
Boulder CO 80302
tel: 303-557-2250
fax: 303-325-7688

This form is to allow the **TAKE TWO HEALTH** team to communicate (speak, call, email, text, etc) with others whom I choose to include on my team to keep me well. Standard communication between my medical providers is already allowed under HIPAA – this form allows me to specifically authorize my medical team to also communicate and collaborate with others whom I choose.

This commonly includes mental health practitioners (therapists, counselors), community advocates (support groups, social services, clergy, etc), complementary and alternative health practitioners, caregivers, and trusted friends and family. I may also choose to include anyone I wish.

The purpose of such communication is to share an understanding of what is happening with my health, so that we can all work together to support me in managing my health and well-being, and to maximize my autonomy and ability to function and reach my health goals.

TAKE TWO HEALTH also has a separate form to authorize the sharing of **DOCUMENTS** from your health record with other healthcare practitioners.

☐ I authorize **TAKE TWO HEALTH** to discuss all aspects of my health with the party listed above.

☐ I authorize **TAKE TWO HEALTH** to discuss **ONLY** the following specific aspects of my health with the party listed above: _____

_____

☐ I authorize **TAKE TWO HEALTH** to discuss my general health with the party listed above, **EXCEPT** for the following information (use general, vague terms, as all parties may see this form): _____

_____

_____

I ☐ **DO** / ☐ **DO NOT** consent for information regarding **MENTAL HEALTH** to be released.

I ☐ **DO** / ☐ **DO NOT** consent for information regarding **USE OF ALCOHOL, DRUGS, AND ILLICIT OR CONTROLLED SUBSTANCES** to be released.

I ☐ **DO** / ☐ **DO NOT** consent for information regarding **HIV STATUS OR HIV TESTING** to be released.

Consent for release of information shall expire:

- ☐ immediately after one single conversation
- ☐ in one year
- ☐ ongoing: this consent will ONLY expire when I provide written notice terminating my consent

You may revoke your consent in writing at any time. If you do not otherwise specify, your consent will be valid for one calendar year from the date of your signature.

_____
Signature of patient or legal representative

_____
Printed Name of patient or legal representative

_____
Relationship to patient

_____
Date