Wholeness Center

Tax ID# 83-1344190
Wholeness Health LLC.
2620 East Prospect Rd., suite #190, Fort Collins, CO 80525
Office: (970) 221-1106
Fax: (970) 232-1050

___ Scott Shannon, M.D., CO medical license # 31090
___ Craig Heacock, M.D., CO medical license # 43403
___ Steve Rondeau, N.D., license # 0000021
___ Mary Rondeau, N.D., license # 0000007
___ Nicole Lewis, N.D., license # 0000117
___ Brooke P. Schneider. D.O. medical license #0057300
___ Cori Ann Stepek, Ph.D. CO psychologist license #2458
___ Lorna Gail Dawson, PMHNP-BC, license #990045
___ Jason Sienknecht, LPC-CACII, license # LPC0005704
___ Jen Strating, MA, BCIAC
___ Doreen Horan, LPC license #LPC0014557

Release of Information or Authorization

I authorize Wholeness Health to release and receive the information indicated to the agency or persons listed below for purposes of service coordination, continuity of care, and case management.

Patient/Client Name: _____ Date of Birth: _____

Information to be released:

_____ All medical and mental health treatment records which includes mental health condition and treatment
_____ Verbal communications, including communications either verbally or written
_____ Drug abuse or alcohol abuse, which includes, if any, alcohol or substance abuse condition and treatment
_____ Other: _____

We are Requesting Information from: ☐ We are Releasing Information to: ☐

***Information required by patient for release to be processed**

*Agency or Person	*Address	*Phone/Fax
_____	_____	_____
_____	_____	_____
_____	_____	_____

- I understand that my records and/or those of any individuals listed above are protected under state and federal 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 the Wholeness Health may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this Authorization. Also, if this is an Authorization, the Center must provide me with a copy.
- I understand and agree that this release form may be sent to the agencies and persons identified above.
- I understand that there is potential for information to be disclosed as a result of this release/authorization to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy regulations.
- This consent expires and cannot be used 2 years from today's date

_____ _____ _____
Signature Print Name Date

_____
If not Patient/Client, please and state your legal authority to sign for Patient/Client