Lauren Cone, PLLC
14143 Denver West Parkway Suite
100 Golden, CO 80401
Phone 512-596-0498

Authorization for Release of Protected Health Information

Patient Name: _____Birth Date: _____

Address:_____

City: _____ TX Zip Code: _____ Phone:_____

I give permission for the following two agencies/persons to share my protected health information:

Name: Lauren Cone, PMHNP.
Address: 14143 Denver West Parkway Suite 100 Golden, CO 80401
City/State/Zip: Golden, CO 80401
Phone: (512) 596-0498

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

☐All Records ☐Psychological Testing ☐Psychiatric Evaluation ☐Progress Notes

☐Medication Information ☐Lab Tests/Medical Imaging
☐Other:_____

I give special permission to share the following information (Please Initial):
____Psychotherapy Notes ____ Alcohol/Drug Abuse

Purpose for Disclosure (Please Check):

☐Continuity of Care ☐At My Request ☐Other:_____

Approximate Dates of Service:

☐Any ☐From: _____ To: _____
☐Other: _____

This authorization can be cancelled at any time by request, in writing, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. This office cannot control how the protected health information will be used by the agency/person who receives it under this authorization. Unless cancelled or otherwise specified, this authorization will expire one year from date of signature.

Other Specified Expiration Date: _____

Patient Signature: _____ Date: _____

Printed Name: _____