RMH

Reiff Mental Health

Authorization For Release of Protected Health Information

Client Name: _____ Date of Birth: _____

Address:_____ Phone Number: _____

I authorize my provider, _____, and Reiff Mental Health to release information from my medical record which may include personal health information (PHI) including diagnoses and prescribed treatment.

Date Range of Requested Records: _____

Information to be released : _____

_____

_____

Name of Recipient: _____

Recipient Mailing Address and/or Fax Number: _____

_____

I understand that this request will automatically discontinue in one year from date signed.

Client Signature: _____ Date:_____

3095 Wilson Court, Denver, Colorado 80205
P/303.803.5726 practice_manager@reiffmentalhealth.com. F/303.484.7339