Wholeness Center

Tax ID # 27-2970598
Wholeness Center P.C.
2620 East Prospect Rd., Suite #190, Fort Collins, CO 80525
Office: (970) 221-1106
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___Scott Shannon, M.D., CO medical license # 31090
___Michael Mullin, M.D., CO medical license # 45840
___Craig Heacock, M.D., CO medical license # 43403
___Brooke P. Schneider D.O. medical license # 0057300
___Steve Rondeau, N.D., license # 0000021
___Mary Rondeau, N.D., license # 0000007
___Nicole Lewis, N.D.license # 0000117
___Annah Schnaitter MA, LPC license #LPC 0011824
___Douglas Fontenot MA
___Cori Ann Ramirez, Ph.D. CO psychologist lic #2458
___Gail Dawson, NP, license 990045
___Connie Randazzo, PMHCNS-BC, license 99244-CNS
___Hugh Castor, LAC
___Jen Strating, MA, BCIAC
___Heather Lee, PA, license# PA0003291

Release of Information or Authorization

I authorize Wholeness Center 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: _____

Information to be released to and from:

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 Center 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 that I may revoke this consent at any time.
- Copies of this form may be used in lieu of the original.
- 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 past the following date (not to exceed 1 year): _____

_____

Signature Print Name Date

_____

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