Asma Ali, PsyD, ABPP
CO License: PSY.0004435
GA License: PSY.003834
Mailing Address: 4833 Front St., Unit B 417, Castle Rock, CO 80104
Mobile Phone: 720.628.9090
Email: DrAli@centeredpeak.com
Website: http://centeredpeak.com

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient legal name

Address **City** **State/Zip**

Phone number(s) **Date of birth**

I hereby authorize: **Centered Peak Behavioral Health & Wellness, LLC**
4833 Front St., Unit B 417
Castle Rock, CO 80104
720.628.9090
DrAli@centeredpeak.com

To ☐ **release** and/or ☐ **receive** the Protected Health Information (PHI) of the patient listed above ☐ **to** and/or ☐ **from**:

Contact Person/Organization

Address **City** **State/Zip**

Phone Number **Fax Number**

Purpose: ☐ **Continue of Care** ☐ **Personal** ☐ **Other:** _____

Pertinent PHI:

☐ **Aptitude or achievement test scores**	☐ **Drug and alcohol treatment**	☐ **Medical records**	☐ **Mental health treatment (assessment, diagnosis, treatment plan, prognosis, discharge/transfer)**
☐ **Progress reports**	☐ **Psychological and/or psychiatric report**	☐ **Report cards/IEP/teacher observations**	☐ **Other:**

☐ **The parties above may discuss my Protected Health Information without limitations.**
☐ **I would prefer to limit the Protected Health Information shared between the parties listed above. Limitations include:**

Acknowledgment: I request and authorize the above-named provider to release/receive the information specified above to the organization, agency, or individual named on this request. I understand that this information to be released/received may include personal information regarding evaluation, treatment, and psychological conditions. I understand that if the received is not a health plan or healthcare provider, the released information may no longer be protected by Federal Privacy regulations and may be redisclosed.
Expiration: Without my express revocation, this authorization will automatically expire one year from the date hereof, unless otherwise specified: _____
Revocation: I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. To revoke authorization, I must submit a written letter to Centered Peak Behavioral Health & Wellness, LLC.
Other Conditions: A copy or facsimile of this authorization with my signature may be used with the same effectiveness as an original. I understand that:

- Please note that you have the right to refuse to sign this form, and that treatment is not conditioned upon your signing this authorization.
- Fees/charges will comply with all laws and regulations applicable to release of information.

My signature below attests that I have read the preceding information, the information has been fully reviewed and explained, and that I understand and agree with its content. I have received a copy of this authorization, once signed.

Patient Signature **Date**

Parent/legal guardian signature, if patient is a minor **Date**

Asma Ali, PsyD, ABPP **Date**