BLOOM
Mental Health

Jadon Webb, M.D., Ph.D.
Shannon Keane, NP-C
26 W Dry Creek Circe, Ste., 710
Littleton, Colorado 80120
p. 303.801.1776
f. 720.306.5515
admin@bloommh.com

AUTHORIZATION for Disclosure of Protected Health Information

Patient Seeking to Disclose Protected Health Information (PHI):

_____

We may obtain information from and share information with:

Failure to complete this section completely may cause a delay in the processing of requests and/or collaboration efforts in the treatment and care of the patient.

Therapist _____ Ph.No.:_____

Email: _____

Physician _____Ph.No.:_____

Email:_____ Fax: _____

Parent(s): _____Ph.No.:_____

Email: _____ Email:_____

School_____Contact Name: _____

Email:_____ Ph.No: _____

Type of information requested: All medical and psychiatric information pertaining to the mental health treatment of the individual above. This includes clinical notes, discussion with the provider in person or by phone, labs, and any additional studies. The dates of treatment requested are for the duration of treatment or contact with this person or provider and the patient, unless otherwise noted:

_____

I have read and understand that:

1) This authorization, unless specifically limited by me in writing, pertains to all aspects of my treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV Infection, alcohol and/or drug abuse, and mental health conditions.
2) This authorization can be limited or revoked in writing by me at any time, except for actions already taken with regard to this authorization. I am not required to sign this authorization to receive treatment at Bloom Mental Health.
3) I recognize that any authorization increases the potential for accidental or intentional re-disclosure by other parties, including disclosure that may not be protected by the same laws as for this practice.
4) Jadon Webb, Bloom Mental Health LLC, and all employees or associates are hereby held harmless from any liability or responsibility from any disclosures to the extent specified and authorized in this authorization.
5) This document will expire within 2 (two) years unless otherwise specified.

I authorize disclosure of my health records as indicated above:

Name of Patient _____

Signature_____Date _____

(if patient is a minor - under18yrs of age - Parent signature required)