MORGAN RECORDS MANAGEMENT
AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS FOR

SOUTHWEST COUNSELING ASSOCIATES

Patient Name: _____ Patient Date of Birth: _____

Name of Health Care Provider: _____ ("Health Care Provider")

Name of Health Care Provider's Entity: Southwest Counseling Center ("Practice")

Address of Health Care Provider/Practice: 141 West Davies Avenue, Littleton, CO 80120

Please check one. These records are:

_____ Individual Records _____Couples Records _____Family Records

Couple and Family Records cannot be released until all parties sign a release form. It is your responsibility to communicate to all parties involved in Couples and Family records that they need to sign release forms. Morgan Records Management will not be responsible for contacting other parties on your behalf to ensure a release form is signed.

I, the Patient identified herein, or a duly authorized Representative as identified below, hereby request and authorize Morgan Records Management, as the records custodian for the Practice, to release and provide all documents and information comprising the Patient Record regarding care and treatment by the Provider and/or the Practice ("Record") to the **Authorized Recipient(s)** identified below.

Identification of the Authorized Recipient of the Record. Indicate Below each Authorized Recipient(s), by checking the Appropriate Box.

___ ONLY SELF/YOU: Address for purposes of requested disclosure, including email address if transmittal is intended to be via e-mail: _____

___ Health Care Provider (the Health Care Provider will receive the entire Record). Address for purposes of requested disclosure, including email address if transmittal is intended to be via e-mail: _____

___ Other: (the Authorized Representative or other Third Party will receive the entire Record). Name and Address for purposes of requested disclosure, including email address if transmittal is intended to be via e-mail:

- Name of Authorized Recipient if other than You personally and other than a Health Care Provider: _____ [Print Name of Recipient]
- Address: _____
- Email: (if delivery of a Record will be by e-mail): _____
- Relationship to Patient: _____ (Example: Guardian; Parent; Attorney).

Special Rules for Patients who are Deceased: If the Record is sought for a former Patient who is deceased, please check this box ____. If this box is checked, you will be provided and required to execute a separate form in accordance with New Hampshire or other state law requirements before Morgan Records will be able to provide the Record.

Proof of Identification. By submitting this Authorization, I am acknowledging that Morgan Records may be required by law to require proof of identification to verify the authenticity and legality of the request for production of a Patient Record. Such proof shall include any identification required by law and deemed sufficient in Morgan Records discretion to reasonably establish authority to obtain the Record. Such proof may include, by way of example only: a photo i.d., submission of verification on agency letter of the authority of a Requestor representing a public office or agency and proof of an agency ID (such as a badge or e-mail address), an executed Power of Attorney form; and/or a Court Order or letter of guardianship for minors. Note: an executed subpoena without an executed valid authorization or other verification may not be sufficient to establish authority to receive copies of a Patient Record.

E-mail Transmittals. Morgan Record recommends transmittal of a Patient Record via secure means such as electronic transmittal through a secure portal, or a disc. Although it is unlikely, there is a possibility that an e-mail communication, and the information in the e-mail, could be intercepted by an unauthorized third party. Because e-mail transmittals are not secure, Morgan Records' policy is to refrain from using unsecured e-mail as a means of transmitting a Patient Record, unless the Authorized Recipient expressly consents, i.e., expressly chooses unsecure e-mail as the means of accomplishing the transmittal of the Patient Record.

In order for Morgan Records to transmit a Patient Record via unsecure e-mail, the following box must be checked as evidence of the consent and approval by the Authorized Requestor for Morgan Records to use unsecure e-mail. ____ Only check this box if you are requesting transmittal of a Patient Record by e-mail.

Special Rules regarding Minors. If the Record is sought by a parent or guardian or legal representative of a minor (i.e., an unemancipated individual who is not yet 18 years of age) please check this box ____. You will be provided information by Morgan Records regarding your legal rights with respect to the Rights of Access to Health Records of Minors.

Timing and Copies.

The authorization is valid for a period of 90 days from the date of signing. I further understand that I may revoke this authorization by written notice to Morgan Records except where Morgan Records has already acted upon a prior written request for the production of the Record.

I understand that I am entitled to a copy of this authorization. A photocopy and/or an electronic transmittal of this authorization shall be considered as effective and valid as the original.

SIGNATURE LINES FOLLOW [ON NEXT PAGE]

Signatures.

Patient Name:

Signature: _____ _____ _____
Date of Birth Date of Signing

Print Name: _____

Signature of Parent or Guardian if Client is a Minor (or Under Guardianship):

Signature: _____ Date of Signing _____

Name of Parent or Guardian: _____ [print]

Relationship: _____

Signature of Authorized Representative (Individual requestor other than Patient, Parent or Guardian of a Minor):

Signature: _____ Date of Signing_____

Requestor: _____ [print]

Title of Requestor and Relationship to Patient: _____

Your completed authorization form may be emailed to Medical@MorganRM.com, or mailed to Morgan Records Management LLC, 8 State Street, Nashua, NH 03063.