ACM Psychiatric Consultants, LLC. *4740 Flintridge Drive, Suite 214* *Colorado Springs, CO 80918* *(719) 357-7617* *Ardis C. Martin, MD*	**Release of Information or Authorization**

Name: (last) (first) (M.I.)	DOB:
Address/Phone#	Social Security No.:

I hereby authorize Ardis C. Martin, M.D to send, receive, exchange, use, or share protected health information about me with:

Name of Person(s)/Organization to receive or provide information:_____.
Address: _____
Phone: _____

I authorize the release of **any and all of the following medical or mental health information, as specified,** which may be contained in my records. (check all that apply)

[ ] AIDS/HIV*	[ ] Medications	[ ] Psychological Evaluations
[ ] Discharge Summary	[ ] Medical Diagnosis	[ ] School
[ ] Drug/Alcohol*	[ ] Medical History	[ ] Treatment Plan
[ ] Intake Evaluation	[ ] Progress Notes	[ ] Other:
[ ] Laboratory Results	[ ] Psychiatric Evaluations	

Purpose of this Disclosure: (check all that apply)

[ ] Assisting in diagnosis and treatment	[ ] Determine program eligibility
[ ] Assuring continuity of care	[ ] Educating family member(s) about mental illness
[ ] Facilitating resident placement	[ ] Referring to another agency/person
[ ] Reporting to probation officer or court	[ ] Other _____
[ ] Coordinating service delivery	

**Requires initials below*

I understand that my record may contain information regarding diagnosis or treatment of drug or alcohol abuse. I give my specific authorization for these records to be disclosed. (42 CFR, Part 2)	Drug/Alcohol (initials)
I understand that my record may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or of sexually transmitted diseases. I give my specific authorization for these records to be disclosed. (RCW 70.24.105)	HIV/AIDS (initials)

I understand that my records may contain information relating to mental health issues (per RCW 71.05.620). This authorization prohibits further use or disclosure of the information being released beyond the specific limits for this consent. I understand that information used or disclosed in keeping with this authorization may no longer be protected by Federal Law and could be used or re-disclosed by the receiving party. This consent is subject to my revocation at any time, except for information previously exchanged. To revoke this authorization I must submit a written request to Ardis C. Martin, M.D. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain enrollment, treatment (or payment, if applicable) from Ardis C. Martin, M.D.

Unless revoked earlier by me, this authorization shall expire either 30 days after the signature date, or upon discharge from mental health services with Ardis C. Martin, M.D., whichever is *later*.

_____ _____

Signature of client, or client's parent/guardian/legal representative Date