Sekou Jones, MSN, PMHNP-BC, FNP-BC, RXN - Calm Clarity Mental Health
7955 E Arapahoe Ct, Suite 3400, Centennial, CO 80112-6829
(303) 898-2267 phone (720) 287-3666 fax office@calmclaritymh.com

Release of Information

(Optional – Complete & sign if there are any clinicians / personal contacts you would allow to communicate with this office regarding your healthcare)

Patient name:		**Date of Birth:**	

By signing this form, I am authorizing Sekou Jones, MSN, PMHNP-BC to ***communicate with the individual(s) listed below for the purpose of disclosing and/or obtaining confidential information.***

PERSON / GROUP AUTHORIZED			
Address:			
	Street Address		
	City, State, Zip Code		
Phone:		Fax or email	

PURPOSE OF DISCLOSURE: By ***initialing*** below, I authorize the disclosure my confidential information to be disclosed and/or obtained **for the following purpose(s)**:

_____ **Collaboration of Treating Clinicians** _____ **Transfer of Care**
Initials ***Initials***

_____ **Communication with Family Member** _____ **Other:** _____
Initials ***Initials***

TYPE OF INFORMATION: By ***initialing*** below, I authorize the following **types of information** to be disclosed or obtained:

_____ **General Medical** _____ **Alcohol or Drug Abuse**
Initials ***Initials***

_____ **Mental Health** _____ **Other:** _____
Initials ***Initials***

Expiration: This authorization is *valid for one year* from the date below *or* until _____, *whichever is earlier*. I understand that *I may revoke this authorization at any time* by signing and dating this original form or by sending a signed, dated request to this clinician.

_____ **X** _____ _____
Client's Name (please print) **Client's Signature** (or responsible party) **Date**

Name and relationship of responsible party (if signing on behalf of client): _____

I hereby ***revoke*** *this authorization as of the date signed* _____ _____
Client's Signature (or responsible party) Date