Authorization to Disclose Protected Health Information
RHM Consulting, LLC.

I hereby authorize Rachel H. Meyer, Ph.D. ("Provider") to disclose to (name and/or function of the person or entity to whom disclosure is to be made)

____
("Recipient") the following protected health information:

____ Entire File
____ Diagnosis
____ Prognosis
____ Modalities & Frequencies of Treatment Furnished
____ Psychotherapy Notes
____ Treatment Plan
____ Progress to Date
____ Other:
____

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.

I authorize the disclosure of the health information described above for the following purpose:

____
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____

The specific uses and limitations on the uses of my health information by Recipient are as follows:

____
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____

I understand that Provider cannot condition treatment upon me signing this authorization.

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable Colorado law.

Provider is authorized to disclose the protected health information specifically listed above until: ______________________________(authorization expiration date).

By: _______________________________Date:_____________________________
(Patient or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative:

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