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*Create Sound Well-Being Through Music*

**AUTHORIZATION TO RELEASE PROTECTED HEALTH AND CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, authorize SoundWell Music Therapy, PLLC and Faith Halverson-Ramos, MA, LPC, MT-BC, to exchange and release the information specified below with the following person/class of persons (Name, Telephone Number, Address, Relationship to Client):

\_\_\_\_\_

CLIENT NAME: \_\_\_\_\_

PARENT/LEGAL GUARDIAN (if applicable): \_\_\_\_\_

CLIENT DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**INFORMATION REQUESTED:** I request and authorize the above-named person or class of persons to exchange and release the information specified below to the above named person or class of persons (check all that apply):

- Evaluations/Testing/Assessments       Psychotherapy Notes       Complete Medical/Mental Health Records
- Treatment Summary       Medications prescribed       Diagnosis/Psychiatric Conditions
- Drug/Alcohol Abuse Information       HIV/AIDs Information       Treatment Plan
- Other: \_\_\_\_\_

**Type/Form of Information Requested (check all that apply):**

- Records    Verbal Communications    Electronic Communications such as texts or emails

I understand that the information to be released includes information for the following **purpose:**

- Psychiatric Condition, Psychological Testing/Assessment       Treatment Planning
- Rehabilitation program, development, or services       Legal Issues
- Coordination of Care       Consultation/Supervision       Education
- Drug/Alcohol Abuse       HIV/AIDS       Medical Care
- Other: \_\_\_\_\_

The information sought in this request is the minimum necessary to accomplish the intended purpose of the request. 45 C.F.R. 164.502(b)(2)(v). (See 65 FED. Reg. 82530). Information may be released verbally, in writing, photocopy, by fax or mail unless client indicates otherwise.

