TMS Center of Colorado, LLC
repetitive Transcranial Magnetic Stimulation Therapy

4770 E. Iliff Ave – Suite 224 – Denver, Colorado 80222 – (303)884-3867 - www.tmscenterofcolorado.com

Consent for Release of Confidential Information

Patient Name: _____ Date of Birth: _____

I herby authorize:

Covered Entity: _____

Address: _____

Address: _____

Telephone:_____ Fax: _____

To release specified information to:

TMS Center of Colorado, LLC
4770 E. Iliff Ave, Suite 224
Denver, Colorado 80222
Telephone: 303-884-3867
Fax: 303-757-7994

This information includes:

☐ Psychological Evaluation ☐ Laboratory Reports ☐ Psychotherapy Notes
☐ Listing of all medications ☐ Medical Records

I understand this information is to be used for:

☐ TMS Consultation ☐ Evaluation
☐ TMS Treatment ☐ Treatment Planning

I understand this information will not be further released without my written consent. I understand that there are regulations protecting the confidentiality of authorized information but that such protection may not apply to the recipient of the information and therefore may not prohibit the recipient from re-disclosing the information I hereby acknowledge that this consent is voluntary and valid for 1 year or until this request is fulfilled. I acknowledge that I may revoke this consent at any time by doing so in writing delivered to the Covered Entity named above and that the revocation will not apply to the use or disclosure of any information that was made pursuant to this authorization before it is revoked. I also understand that the Covered Entity may not condition treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed knowing that action may have already been taken.

_____ _____

Signature of patient or legal guardian Relationship to patient

Date:_____ Witness:_____