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AUTHORIZATION TO RELEASE INFORMATION

I, **(name of patient)** ______________________________, (hereinafter "Patient") hereby authorize **(name of psychotherapist)** ______________________, (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to/from:

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I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization 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. And, I also understand that such revocation must be in writing and received by Provider at **1006 Depot Hill Road, Broomfield, CO 80020** to be effective.

This disclosure of information and records authorized by Patient is required for the following reason(s): ____Consultation/Psychotherapy
____ Evaluation
____ Continuity of Care
____ Other

The Patient understands that this release may include information about:
_____Alcohol/Substance Abuse/Dependence _____AIDS/HIV
_____Psychiatric Concerns

The specific uses and limitations of the types of medical information to be discussed are as follows **(be as specific as you choose to)**:

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Such disclosure shall be limited to the following specific types of information:

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Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form. Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Colorado law may protect such information.

This authorization shall remain valid until:

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Patient's signature: _____________________________Date____________
Parent/Guardian's Signature______________________ Date____________
Therapist's Signature____________________________Date____________