



AUTHORIZATION TO RELEASE & EXCHANGE INFORMATION

Client: _____ **Agency:** _____
 _____ **ATTN:** _____

Client Name: _____ **DOB:** _____ **Record#:** _____

I, _____, hereby authorize _____
 (client name) (agency or person releasing/exchanging information to DPCS/Noeticus)
 to exchange information with Denver Psychotherapy and Consultation Services, LLC and/or Noeticus Counseling Center.

Purpose(s) or need for which information is to be used:

- Continuity of Service Provision Other _____

Information to be Released:

- | | | |
|--|--|---|
| <input type="checkbox"/> Presence in Treatment | <input type="checkbox"/> Educational Information | <input type="checkbox"/> Psychiatric History |
| <input type="checkbox"/> Verbal and Written Progress | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Medication History |
| <input type="checkbox"/> Treatment Plan/Recommendation | <input type="checkbox"/> Probation/Parole Conditions | <input type="checkbox"/> Psychosocial History |
| <input type="checkbox"/> Copy of Aftercare Plan | <input type="checkbox"/> Financial Information | <input type="checkbox"/> Criminal Justice History |
| <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other _____ |

I understand that information to be released may include information regarding the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Chemical Abuse and/or Dependency | <input type="checkbox"/> Psychiatric Conditions | <input type="checkbox"/> HIV/AIDS Testing or Status |
| <input type="checkbox"/> Criminal Records | <input type="checkbox"/> Judiciary Recommendations | <input type="checkbox"/> Other _____ |

IMPORTANT NOTE:

If the information to be released pertains to the diagnosis and treatment of alcoholism and/or drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42 C.R.S. Part 2.

Authorization:

I certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has been taken to comply with it. I understand that this consent will expire upon termination of therapy or upon _____. I hereby release any service provider or individual from any liability, which may result from furnishing the information requested as authorized in this release. Redislosure of my medical records **may not** be accomplished without further written consent.

A COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

Client Name: _____

Client Signature: _____ Date: _____

Therapist/Witness: _____ Date: _____

Last Update 11/23/2007