LEGACY COMPREHENSIVE COUNSELING & CONSULTING
19751 E. MAINSTREET SUITE 215 - PARKER CO 80138
WWW.LEGACYPARKER.COM - PHONE: 303-841-4005
OR INFO@LEGACYPARKER.COM

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I (we), _____ [Insert Name of Client or Caregiver] authorize Legacy Comprehensive Counseling & Consulting to release and obtain information regarding:

(Client, or caregiver, should **initial each item** to be release and/or obtained)

_____ Psychological Evaluation
_____ School Behavior
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Billing/Payment Information
_____ Diagnosis
_____ Toxicological Reports/Drug Screens
_____ Nursing/Medical Information
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Scheduling / Cancelling Appointments
_____ Presence/Participation in Treatment
_____ Other _____

about me and/or my child:

Name _____ Date of Birth _____

To and From: _____
(name of doctor, school, clinic, hospital, etc.)

_____
(street address)

_____
(city) (state) (ZIP code)

_____ _____
(phone number) (fax number)

If you do not want certain parts of your records released, please initial the lines beside the type of information you do not want released. Otherwise, your records will be released as specified above.

_____ Substance abuse, if any
_____ AIDS/HIV, if any
_____ Other _____

I understand that the purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I understand that I may revoke this authorization, in writing, at any time by sending written notification to Legacy Comprehensive Counseling & Consulting at 19751 East Mainstreet, Suite 215, Parker, CO 80138. I also understand that unless I specify an earlier date it will automatically expire upon my termination or discharge from treatment at Legacy Center. I understand that if Legacy Comprehensive Counseling & Consulting has released information based on this authorization before I revoke it, Legacy Comprehensive Counseling & Consulting cannot get the information back. I also understand that Legacy Comprehensive Counseling & Consulting has no control over information released to anyone else and that those recipients may disclose such information. I understand that a copy of this authorization may be used in place of the original. I understand that authorizing the disclosure of this health information is voluntary. I need not sign the form to ensure treatment. I understand that I can inspect the information to be disclosed. I will be given a copy of this authorization for my records.

Signature_____ Printed Name_____ Date _____
Client's Signature (15 years or older)

Signature_____ Printed Name_____ Date _____
Signature of Parent, Guardian or Personal Representative (if patient under 15)

Signature_____ Date _____
Therapist's Signature, Legacy Comprehensive Counseling & Consulting