



LEGACY CENTER
 19751 E. MAINSTREET SUITE 218 - PARKER CO 80138
 PHONE: 303-841-4005 - FAX: 720-851-4890
 INFO@LEGACYPARKER.COM - WWW.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 | _____ Diagnosis |
| _____ School Behavior | _____ Toxicological Reports/Drug Screens |
| _____ Educational Information | _____ Nursing/Medical Information |
| _____ Discharge/Transfer Summary | _____ Continuing Care Plan |
| _____ Treatment Plan or Summary | _____ Progress in Treatment |
| _____ Current Treatment Update | _____ Scheduling / Cancelling Appointments |
| _____ Medication Management Information | _____ Presence/Participation in Treatment |
| _____ Billing/Payment Information | _____ 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