Authorization for Release of Information From and To FIRST Counseling, LLC

970-773-5727

www.first-counseling.com

Client Name _____ Date of Birth _____

Address _____

City/State/Zip _____

Phone _____

Parent/Guardian/Requestor Completing This Form_____

RELEASE FROM and TO

I authorize the following person/institution to release Medical Record information:

Name _____

Address _____

City/State/Zip _____

Phone _____ Fax_____

Therapist from FIRST Counseling, LLC:

Name: **Kyle Davis, MA, LPCC**

Phone: **970-773-5727**

INFORMATION TO RELEASE

___ Complete Medical Record

___ Other: _____

State/Federal Laws require specific authorization to release the following types of information. Please initial beside the types of information to be released:

_____ Mental Health _____ Psychotherapy Notes _____ Drug/Alcohol Abuse _____ HIV/AIDS Related

PATIENT/AUTHORIZED REPRESENTATIVE AUTHORIZATION I understand that: (1) My signature on this form is strictly voluntary. (2) I may revoke this authorization at any time in writing, and if I do it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. (3) If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. (4) If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected. (5) I may inspect or obtain a copy of the health information that I am being asked to disclose. Expiration: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 365 days from the date hereof.

_____ _____ _____

Signature Relationship to Client Date