OFFICIAL RELEASE OF CONFIDENTIAL INFORMATION

Date: _____

Client Name: _____ Date of Birth: _____

I hereby authorize Columbine Counseling Center P.C. to:
(Check either or both boxes)

☐ obtain information from ☐ release information to

_____ (Agency)

_____ (Attention)

_____ (Street Address)

_____ (City, State, Zip)

_____ (Phone Number)

The specific materials requested or to be released are listed below:

☐ Medical Records
☐ Laboratory Data
☐ Progress Reports
☐ Summary of Treatment
☐ Dates of Treatment Only
☐ Psychological Test Records
☐ Diagnosis
☐ Educational/School Records
☐ Academic, social, daily presentation, and family information
☐ Other

I understand that I have the right to revoke this authorization, in writing, at any time but my revocation will not be effective to the extent that action has been taken in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contact a claim. I understand that my health care provider generally may not condition health care services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of these records and no longer protected by the HIPAA Privacy Rule.

Columbine Counseling Center, P.C. is not responsible for any information forwarded to other parties once it is released.

This release is in effect for 90 days from _____ unless otherwise specified.

_____
Signature of Client

_____
Witness

_____
Signature of Guardian