SOUTHEAST FAMILY COUNSELING
6436 South Quebec Street, Suite 100, Englewood, Colorado 80111

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ________________________________, hereby authorize Robert L. Feder, LCSW and__________________
Client or parent of minor child   Name

____, at__________________, ______________
Title   Address   Telephone   Fax

to exchange information.
The type of information to be disclosed:

Evaluations ______	Medical/Hospital Records ______
Diagnosis ______	Psychological/Medical Test Results ______
Treatment Plan ______	Mental Health Record Summary ______
Course of Treatment ______	Psychotherapy Notes ______
Other ____	

The purpose of such disclosure:

Ongoing Treatment ______	Medical Care ______	Consultation ______
Evaluation ______	Transfer _____	Legal Issues ______
Coordination of Care______	Health Benefit Utilization______	
Supervised Visitation______	CFI Case ______	Other _____________________

Exceptions: ____

The designated information about me or my child ( ) may ( ) may not be transmitted by fax, email or other electronic file transfer mechanisms. Sharon S. Feder and the above designated person ( ) may ( ) may not discuss by telephone the content of the information released.

This consent is in effect until _____________ or one year from today. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my or my child's communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault, abuse or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

____ ________________________________ __________
Signature of Client, Personal Representative or Parent of minor   Print Signer's Name   Date

____ ____________________
Minor's Name (print)   Minor's Date of Birth

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION