

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

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize Sharon S. Feder, MS 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