Cherry Creek Psychotherapy, LLC
Patrick Thomas Cole, MSW, LCSW

HIPAA Authorization For Release of Information

I (We) authorize Cherry Creek Psychotherapy, LLC
Patrick Thomas Cole, MSW, LCSW
1660 South Albion Street, Suite 1025
Denver, Colorado 80222

To release and disclose information pertaining to the clinical record of:

_____ _____
(Name of client/recipient of mental health services) (Date of birth)

to and from the following provider(s) listed below (two-way release):

_____
(Provider)

_____
(Address)

Nature of information: _____
(State specific nature of information to be disclosed)

For the purposes of Two way communication between CCP and Provider listed.

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Cherry Creek Psychotherapy, LLC and Patrick T. Cole, MSW, LCSW. I understand that a revocation is not valid to the extent that Cherry Creek Psychotherapy, LLC and Patrick T. Cole, MSW, LCSW has acted in reliance on such authorization. This authorization is valid during the course of treatment with Patrick Cole, LCSW, unless otherwise specified.

_____ _____
(Client Signature 12,yrs or older) (Date) (Responsible Party Signature) (Date)

_____ _____
(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.