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

Authorization For Release Of Information

I, _____(Client), hereby authorize Cherry Creek Psychotherapy, LLC and Patrick T. Cole, MSW, LCSW and_____ _____(Name), at _____(Phone) to exchange information.

The type of information to be disclosed:

Evaluations _____
Diagnosis _____
Treatment Plan _____
Course of Treatment _____
Other _____

Medical/Hospital Records _____
Psychological/Medical Test Results ____
Mental Health Record Summary _____
Psychotherapy Notes _____

The purpose of such disclosure:

Ongoing Treatment ____ Medical Care ____Consultation ___Evaluation ___
Transfer ____ Legal issues ____Coordination of Care ____
Health Benefit Utilization _____
Other _____

Exceptions: _____

The designation information about me ( ) may ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Patrick Thomas Cole, MSW, LCSW and the above designated person ( ) may ( ) may not discuss, by telephone, the content of the information released.

This consent is in effect until _____. 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 communication 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 in the case of licensed clinical social workers, 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 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.

_____ _____

Date **Signature of Client or Responsible Party**

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

This authorization to disclose private health information is for the release of psychotherapy notes or purposes other than my treatment, payment or the related operations of the practice, and I understand that my authorization, or refusal, will not affect my ability to get treatment or payment. However, the Practitioner can condition those things (1) if my treatment is related to research, or (2) if my treatment is being provided to me solely for the purpose of creating protected health information for disclosure to a third party.

By my signature below, I acknowledge a receipt of this disclosure.

Date: _____

_____

Signature of Client or Responsible Party