



Rudden Counseling Services, LLC

Authorization For Release of Information

This release also serves a request for information

I, _____ (Client Name), _____ (Date of Birth)

do hereby authorize Rudden Counseling Services, LLC and

(Name of other Agency) (Address) (City) (State) (Zip)
(Contact Person) (Phone) (Fax/Email)

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
Other

The designated information about me may or may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms.

Rudden Counseling Services, LLC and the above designated person may or may not discuss by telephone the content of the information released.

I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take 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 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 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.

Expiration Date _____.

(Consumer Signature) (Date)

(Parent, Guardian Signature) (Date)

(Therapist Signature) (Date)