DOROTHY R. SANCHEZ, LPC
5912 S. Cody Street, Suite 110
Littleton, CO 80123
720-275-6890

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip:_____

Phone: _____ Today's Date: _____

I authorize Dorothy R. Sanchez, LPC to (please check appropriate box):
☐ __release information to
☐ __obtain information from

_____ _____
Name of Person, Provider or Facility Address

_____ _____
Phone #/ Fax# (include area code) City, State, Zip Code

PURPOSE OF THIS REQUEST: (check one)
☐ Social Security / Disability ☐ Personal ☐ Other
☐ Insurance ☐ Psychological Testing
☐ Legal Continued ☐ Healthcare

TYPE OF RECORDS / COMMUNICATION AUTHORIZED: (check all that apply)
☐ Psychiatric/Psychological Evaluation and/or Treatment
☐ Medical Evaluation and/or Treatment
☐ Disordered Eating Evaluation and/or Treatment
☐ Drug/Alcohol Evaluation and/or Treatment
☐ Verbal Communication with Person, Provider, or Facility

SPECIFIC INFORMATION AUTHORIZED: (select all that apply)

☐ Assessment Reports
☐ Clinical Notes
☐ Diagnostic Impression Treatment Summary/Plan
☐ Consultation Reports
☐ Other: (please describe)_ _____

SPECIFIC INFORMATION NOT AUTHORIZED: (please describe thoroughly)

_____
_____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. My authorization will expire:

☐ When the requested information has been sent/received.
☐ 90 days from this date.
☐ Other: _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire:

☐ When I am no longer receiving services from Dorothy R. Sanchez, LPC.
☐ One year from this date.
☐ Other: _____

Signature of Client: _____ Date: _____

Relationship to Client (if requester is not the client):

☐ Parent ☐ Legal Guardian ☐ Other: _____

Reason client is unable to sign:

☐ Minor ☐ Deceased ☐ Gravely Disabled ☐ Other: _____

Therapist's Name: _____

Therapist's Signature: _____

Date:_____