
## AUTHORIZATION FOR THE RELEASE OF INFORMATION (ROI)

I, _____, hereby authorize McLaughlin Counseling to release and exchange relevant treatment information throughout the duration of therapeutic treatment and/or the entirety of my legal case. Should my treatment with McLaughlin Counseling extend past one year from the date of this ROI, McLaughlin Counseling will provide me with a new one-year ROI to sign.

**The people to whom information may be released and/or exchanged:**

_____ Caseworker(s) _____

_____ DHS Supervisor(s) and Case Staff _____

_____ Probation Officer(s) _____

_____ Guardian Ad Litem(s) _____

_____ Respondent Attorney(s) _____

_____ Additional Treating Therapist(s) _____

_____ School Personnel _____

_____ Mental Heath Doctor(s)_____

_____ Medical Doctor(s) _____

_____ Clinical Consultant(s) _____

_____ Family member(s) and/or friend(s) _____

_____ Other _____

**The type of information to be released:**

_____ Evaluations and/or Assessments

_____ Diagnosis

_____ Treatment Plan

_____ Projected Length of Treatment

_____ Case notes

_____ Monthly Therapeutic Contact Summaries

_____ Clinical Opinions

_____ Attendance and/or Billing

_____ Other _____

**The purpose of such disclosure:**

_____ Court Involvement

_____ DHS Involvement

_____ Assessment and/or Evaluation

_____ Coordination of Care

_____ Meeting Attendance

_____ Clinical Consultation

_____ Other _____

**The methods for releasing information:**

_____ Written reports and/or updates

_____ Verbal reports and/or updates

_____ Fax, electronic mail or other electronic file transfer mechanisms

_____ Non-clinical voicemails left on phone(s)

_____ Non-clinical text messages on phone(s)

_____ Other _____

I understand that I may revoke this authorization, in writing, at any time, unless action based on this ROI 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. This ROI serves as my written authorization. Without such consent, the information provided by a client during therapy sessions is legally confidential in the case of licensed professional counselors, 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, to abuse or neglect of children, and to court involvement. I further understand that the potential exists for re-disclosure of my private mental health information. I certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information have been explained to me. I acknowledge that I have been offered a copy of this Authorization for the Release of Information.

| _____ | _____ | _____ |
|---|---|---|
| Client Signature | Printed Name | Date |
| _____ | _____ | _____ |
| Client Signature | Printed Name | Date |
| _____ | _____ | _____ |
| Provider Signature | Printed Name | Date |