DLB Counseling & Consulting, LLC
4905 N. Union Boulevard, Suite #200
Colorado Springs, CO 80918
Phone: 719-459-9928 Fax: 719-452-3928
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Authorization to Disclose Protected Mental Health Information

Patient Name: SSN:
Address: Birth Date:
Telephone: Primary Care Physician:

Health Care Information From/To:	**Release From/To:**
	DLB COUNSELING & CONSULTING, LLC AND CLINICAL CARE MANAGEMENT TEAM Tel: 719-459-9928 Fax: 719-452-3928

I authorize the above-named health care provider to disclose the privileged information specified below to the organization, agency, or individual named on this request:

INFORMATION REQUESTED:

Place/Dates of Service: **DLB Counseling & Consulting, LLC / All Dates of Service**

_____ (initial) ☐ Any and all applicable behavioral health and/or substance abuse information pertinent to the continuity and coordination of my care and treatment.

☐Progress/Treatment Reports	☐ Evaluation/Test Results	☐ Treatment Summary
☐Discharge Summary	☐ Diagnosis	☐ Course of Treatment
☐Attendance	☐Treatment Plan	☐ Progress Notes
☐Psychological/Medical	☐ Entire Mental Health Record	☐ Other (Please Specify):

☐ Exclude the following information:

Purpose of disclosure/why information required**:**

☐ Coordination of Care	☐Transfer of Care	☐ Medical Care
☐ Billing/Claims	☐ Legal Issues	☐ Consultation
☐ Ongoing Treatment	☐ Evaluation	☐ Health Benefit
☐ Other (Please Specify):		

The designated information about me ☒ **may** ☐ **may not** be transmitted by fax, electronic mail or other electronic file transfer mechanisms. My clinician and the above designated person ☒ **may** ☐ **may not** discuss by telephone the content of the information released.

I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, and drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

I hereby release all parties state 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 curing 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, and to assault or neglect of a child or elder.

AUTHORIZATION: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility privacy officer or their designee and that it will expire at the end of litigation involving me. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. **This authorization expires 365 days from date of patient's or representative's signature below, unless otherwise specified:** . If I have authorized disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be valid as the original.

I understand that authorization of disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee will be charged for any copy of my health record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the facility privacy officer or their designee.

Signature: _____ Date: _____

Patient (Parent or Guardian if patient is a minor)

Minor's signature is required for release of any records for treatment that the minor may have authorized.

RELATIONSHIP (if other than patient): _____

IDENTIFICATION OF PATIENT OR DESIGNATED REPRESENTATIVE

☐ Drivers License # _____ ☐ Passport # _____

☐ State ID # _____ ☐ Other ID # _____