Ponderosa Counseling Center
Release of Information

Patient Name:_____ Date of Birth:_____

I, _____, hereby authorize the mutual exchange of information between:
(name of patient or guardian)

Katie Glist, MA, LPC
11027 S. Pikes Peak Drive #202 · Parker, CO 80138
Phone: 720-542-3487 Fax: 720-542-3566

and

_____
(name of hospital, physician, school, teacher, etc.)

_____
(address including city, state, and zip code)

_____ _____
(phone number) (fax number)

I understand that information to be released for the purpose of psychiatric evaluation and ongoing treatment may include information regarding the following condition(s):

- Psychiatric Conditions, Psychological Testing, Progress Notes, Medications Prescribed
- Assessment including Diagnosis - Treatment Summary, Recommendations, Consultation
- Drug and/or Alcohol Abuse
- Medical/Educational Information
- HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immunodeficiency Syndrome)

I understand that I may revoke this consent to release medical information at any time by giving written notice to Ponderosa Counseling Center except to the extent that action has already been taken to comply with it. Without such revocation, this consent is valid until treatment with Ponderosa Counseling Center ends.

I release Ponderosa Counseling Center from all legal responsibility and liability for the information released according to the terms of this written consent. I understand that there is the potential for this protected health information to be re-disclosed by the recipient and thus no longer protected under the HIPAA privacy rule.

Signature of Patient: _____ Date: _____
(if 15 years or older)

Signature of Parent or Legal Guardian: _____ Date: _____

Relationship to Patient: _____

Signature of Witness: _____ Date: _____