Renee Storm, LPC, CAC III, CSAT, EMDR
14960 Woodcarver Rd. Ste. #202
Colorado Springs, CO 80908
720-281-0495

Consent for the Release of Confidential Information

I understand that information shared, verbally or in writing, is protected under federal regulations and cannot be disclosed without my written consent. This consent may be revoked in writing at any time by myself, except to the extent that Renee Storm, LPC, CAC IIII, CSAT, EMDR has already acted in reliance on it, and in any event expires **one year** from the date of my discharge or as otherwise specified here: _____

I, _____, authorize Renee Storm, LPC, CAC III, CSAT, EMDR to **RELEASE and RECEIVE** the following confidential information about me.

The information listed below may be disclosed to the designated person(s)/agency below:

ALL (General Protected Health Information, Demographic data, dates of service, diagnosis, psychological evaluation, treatment plan, assessment of treatment progress) _____

Demographic data _____ **treatment goals**_____ **progress & needs** _____

diagnosis _____ **evaluations** _____ **attendance and financial information** _____

other: _____

Name:_____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Name: _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Specific type of information to be disclosed/requested is (check all that apply):

____ Fax and or Email Copies
____ Paper Copies
____ Verbal Exchange of PHI
____ Other (please specify):

_____ _____-
Client Signature Date Witness Date

Consent by Person Other Than Client

If client is under 18 years of age or otherwise unable to consent, the following must be completed:

I, _____ hereby certify that I am the

_____ of the client; that the client is unable to consent

because he/she is a minor, _____ years of age or because:_____.

_____

Parent or Guardian Signature Date

_____

Therapist Signature Date