AUTHORIZATION TO RELEASE INFORMATION

I authorize: _____ Office: 303.639.5240
Centus Counseling, Consulting & Education Fax: 303.639.5243
2696 S. Colorado Blvd. Suite 380 Denver, CO 80222

To release to: Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

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_____ Diagnosis, Services Provided, Dates

_____ Psychological Testing Information

_____ Treatment Summary

_____ Medical History; Physical Exam

_____ Assessment Report

_____ Conversation as needed for ongoing treatment planning and continuity

_____ Other _____

This information will be used for my evaluation, treatment, and follow-up care, and/or to determine benefits payable and claim insurance for treatment services.

I hereby release both of the above parties from any liability that may result from furnishing the information released. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that, in any event, this consent shall expire 90 days after completion of services provided by Centus Counseling, Consulting and Education.

Redisclosure is prohibited. Federal regulation 42 C.F.R., Part 2, prohibits any further disclosure of this information, except with the specific written consent of the person to whom it pertains. It is understood that the policy of Centus Counseling, Consulting and Education is to release only that information about a client or a former client, which in the judgment of the Executive Director is considered essential to the purposes for which authorization is requested.

Date: _____ Client Name: _____ DOB _____
(PRINTED)

Witness:_____ Client Signature: _____

Parent/Legal Guardian _____