Grace Counseling
7921 Southpark Plaza, Suite 204
Littleton, CO 80120
720-489-8555/Fax: 720-489-8304

Consent for Release of Confidential Information

Client Name: _____ **DOB:** _____

Address: _____

_____

Phone: _____

I,_____hereby authorize _____LPC, PhD, PsyD, CNS, LCSW, DVOMB at Grace Counseling, to release information to and obtain information from:

TO/FROM:

_____
Name of hospital, physician, clinic, school admin/faculty/etc.

_____
Address of hospital, physician, clinic, school admin/faculty/etc.

_____
City, State, Zip Code

_____ _____
Telephone number ***Fax number***

I understand that information to be released/authorized for the purpose of counseling and ongoing treatment may include information regarding the following conditions (**THIS MUST BE INITIALED, NOT JUST CHECKED**):

_____Psychiatric Conditions/Treatment/Psychological Testing
_____Drug Abuse
_____Alcoholism or Alcohol Abuse
_____Medical Information/Medications Prescribed
_____HIV/Autoimmune Deficiency Syndrome (AIDS)
_____Treatment Summary, Recommendations, Consultation
_____Social History
_____Educational Information
_____Payment and/or Scheduling
_____Other

I further understand that I may revoke this release/authorization at any time by giving written notice to _____(therapist's name) **at Grace Counseling except to the extent that action has already been taken to comply with it, upon termination at Grace Counseling, or upon minor's age of majority.**

_____ _____ _____
Print Patient Name (if 15 years or older) **Signature of Patient (if 15 years or older)** **Date**

_____ _____ _____
Guardian Name **Guardian Signature/Relationship to client** **Date**

A photocopy of this document shall be as effective as the original

IF YOU ARE FAXING MORE THAN 25 PAGES, PLEASE MAIL TO OUR OFFICE