

Mary Costello Stevens, LPC
6021 S. Syracuse Way, Suite 111
Greenwood Village, Colorado 80111
Phone: 303-380-7070

**AUTHORIZATION FOR RELEASE
OF CONFIDENTIAL AND PROTECTED HEALTH INFORMATION**

Client Name: _____
Parent/Legal Guardian (if applicable): _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____

**I, _____ give authorization and permission to
Mary Costello Stevens, LPC to:**

Release to Obtain from Exchange with

Name: _____
Address: _____
Phone: _____

The following specific information only:

- | | | |
|---|--|--|
| <input type="checkbox"/> Verbal summary and discussion of treatment | <input type="checkbox"/> Record of attendance only | <input type="checkbox"/> Evaluations/Testing reports |
| <input type="checkbox"/> Treatment summary | <input type="checkbox"/> Complete Medical/Mental Health record | <input type="checkbox"/> Treatment plan |
| <input type="checkbox"/> Diagnosis/Psychiatric conditions | <input type="checkbox"/> Drug/Alcohol abuse information | <input type="checkbox"/> Psychotherapy Notes |
| <input type="checkbox"/> Other: _____ | | |

The purpose of this release is:

- | | | |
|---|--|---|
| <input type="checkbox"/> Coordination of care | <input type="checkbox"/> Treatment planning | <input type="checkbox"/> Legal issues |
| <input type="checkbox"/> Testing/assessment | <input type="checkbox"/> Condition of court order/parole | <input type="checkbox"/> At the request of the client |
| <input type="checkbox"/> Other: _____ | | |

I understand the following: *(See CFR §164.508(c)(2)(i-iii))*

- **This authorization will expire in one (1) year from the date of signing, unless otherwise specified here:** _____.

- **The disclosure of health information is voluntary and I have the right to refuse to sign this authorization.**
- **I have the right to revoke this authorization in writing at any time, except to the extent information has already been released in reliance upon this authorization, by providing written notice to the provider's address on this form.**
- **The information released in response to this authorization may be re-disclosed to other parties by the recipient, in which case it would no longer be protected by federal privacy regulations.**
- **Unless the purpose of this Authorization is to determine payment of a claim or benefits, my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.**
- **If I have authorized the release of Drug or Alcohol conditions, Federal Law (42 CFR Part 2) protects the confidentiality of this information.**

Client Signature

Printed Name

Date

Relationship to Client (if applicable)

Any facsimile, photocopy, or other reproduction of this authorization is authorization to release the requested information.