Constance Anne Klein, LCSW
Tree of Life Psychotherapy LLC
1705 S. Pearl Street, Suite #6
Denver, Colorado 80210
720.261.4459

AUTHORIZATION TO REQUEST/RELEASE PATIENT INFORMATION

I, _____, do hereby authorize Constance Klein, LCSW to request/release information regarding my mental health and/or substance abuse treatment from/to: _____
(Name)

_____
(Address)

_____
(Phone)

Purpose(s) or need for which this information is to be used:

[ ] Continuity of medical care
[ ] Disposition planning
[ ] Transfer of care
[ ] Other _____

I understand that information to be released may include the following:

[ ] Intake evaluation
[ ] Discharge evaluation
[ ] Progress notes
[ ] Verbal communication about treatment
[ ] Other _____
_____

If there are any restrictions on the information to be released to the person or agency listed above, please specify those restrictions: _____
_____

AUTHORIZATION: I certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time except to the extent that the action has already been taken to comply with it. Otherwise, this consent will expire 180 days from the date of signature. I hereby release both parties from liability, which may result from furnishing this information. The health care provider cannot be responsible for misuses of information disclosed pursuant to this release. A copy of this authorization is to be considered as valid as the original.

I understand that if I have authorized the release of DRUG AND/OR ALCOHOL ABUSE information, the confidentiality of this authorization is protected by Federal Law (42 CFR, Part 2).

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent, if patient is a Minor Date

_____ _____
Signature of Witness Date