Authorization to Release / Request Information

I, ______________________________ hereby authorize Seeds of Change Therapy, LLC & Cheryl Kosmerl, MSW, LCSW to release and request confidential information with (name & contact information):

____

Initial below to demonstrate your agreement for the type of information that may be disclosed:

_________ Evaluations _________ Medical / Hospital Records
_________ Diagnosis _________ Psychological Test Results
_________ Treatment Plans _________ Mental Health Record Summary
_________ School / Work _________ Course of Treatment
_________ Other_____________

Initial the purpose for such disclosures:

_________ Ongoing Treatment _________ Medical Care
_________ Legal Issues _________ Evaluation
_________ Transfer / Discharge_________ Coordination of Care
_________ Consultation _________Other_______________________

Exceptions: ____

The designated information about me ( ) may ( ) may not be transmitted by fax, electronic mail, or other electronic file transfer mechanisms. Cheryl Kosmerl, MSW, LCSW and the above designated person ( ) may ( ) may not discuss by telephone the content of the information released. This consent if valid for current and past services this person receives. This release will be good for one year following the end of treatment services. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original. I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children. I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Federal regulations prohibit the recipient of this information from making any further disclosures of this information.

___________________________ ___________________________
print client's name client's signature

___________________________ ___________________________
print parent / guardian's name parent / guardian's signature

planting a seed for a healthier tomorrow

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