Request/Authorization to Release Confidential Records and Information

Joy Lanzano, New Growth Psychotherapy llc.
100 Arapahoe, Suite 8
Boulder, CO. 80302

Name:_____ Date of Birth:_____

I authorize that information may be exchanged between:

Name:_____ Relationship to Client:_____

Address: _____ Phone: _____

And Joy L. Lanzano

for the following purpose(s):

❑ Further mental health evaluation, treatment, or care ❑ Rehabilitation program development or services

❑ Treatment planning ❑ Research ❑ Other: _____

These records concern the time between _____ and _____.

In the boxes below, the information to be disclosed is marked by an X, the items not to be released have a line drawn through them.

❑ Intake and discharge summaries
❑ Mental health evaluations
❑ Progress notes, and treatment or closing summary
❑ Other:
_____

❑ Please forward the records to the address in the letterhead at the top of this form.
I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 365 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____ _____ __
Signature of client Printed name Date

_____ _____ _____
Signature of parent/guardian/representative Printed name Relationship Date