Morgan Kautz
Intern Counselor
3035 W 25th Ave
Denver, CO 80211
720-443-3117

Authorization to Release Information

I, _____, (hereinafter "Client") hereby authorize People House, (hereinafter "Provider") to **disclose & receive** mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, therapist's diagnosis of Client, **to/ from***:*

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such **revocation must be in writing and received by Provider** at 3035 W. 25th Avenue, Denver, Co 80211
to be effective.
This disclosure of information and records authorized by Client is required for the following purpose:

_____

The specific uses and limitations of the types of medical information to be discussed are as follows (be as specific as you choose to):

( ) Presence in Treatment	( ) Educational Information
( ) Discharge Summary	( ) Psychosocial History
( ) Treatment Plan/Recommendation	( ) Psychiatric History
( ) Copy of Aftercare Plan (if applies)	( ) Psychological Evaluation
( ) Criminal Justice History	( ) Medication History
( ) Probation/Parole Conditions	( ) Physician's Orders
( ) Verbal and Written Progress	( ) Other_____

I understand that information to be released may include information listed above and/or information regarding the following:

( ) Chemical Abuse and/or Dependency	( ) Psychiatric Conditions
( ) Criminal Records	( ) Judiciary Recommendations
( ) HIV/AIDS Testing or Status	( ) Other _____

Therapist shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form. 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 action has been taken to comply with it. I hereby release any service provider or individual from any liability, which may result from furnishing the information requested as authorized in this release.

The Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

This authorization shall remain valid until: _____

A COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL

CLIENT SIGNATURE _____ DATE:_____

THERAPIST SIGNATURE_____ DATE:_____