Inner Source
Psychotherapy & Consultation Services

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# AUTHORIZATION TO RELEASE INFORMATION

**Date: _____Client Name: _____ DOB:_____ Ph:_____**

I, _____, (hereinafter "Patient") hereby authorize **Beth A. Firestein, Ph.D.,** (hereinafter "Provider" or "Practitioner") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to:

Physician Name: _____Phone:_____
Address: _____Fax:_____
_____
email: _____

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 200 E. 7th Street, #406, Loveland, CO 80537, to be effective.**

The disclosure/exchange of information and records authorized by Patient is required for the following purpose: _____
The specific uses and limitations of the types of medical information to be discussed are as follows: _____

Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form. Patient 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 HIPAA Privacy Rule.

This authorization shall remain valid until: _____

Patient's Signature: _____ Date: _____
Patient Email: _____
Witnessed by:_____

**Confidential Material**

| | |
|---|---|
| **If you receive this information in error, please call (970) 635-9116 to arrange for return of material.** | **This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Fed Regulation (42 CFR, Part 2) prohibits you from making further disclosure without the specific written permission of patient.** |

# Authorization/Release of Information
# Clients Rights and Responsibilities

**Date: _____Client Name: _____ DOB:_____ Ph:_____**

This disclosure is for the purpose of ___Treatment, ___Payment, ___Operations, ___the Release of General Client Records, ___Psychotherapy Notes, ___Other _____.
If "the Release of Psychotherapy Notes" or "Other" is checked, regardless of whether additional purposes are also checked, this form is a HIPAA compliant Authorization. As such, the Provider/Practitioner may not condition treatment, payment, enrollment in a health plan, or eligibility for heath plan benefits on your signing this Authorization. However, the Practioner/Provider can condition those things if, (1) the treatment is research-related treatment and the Authorization is needed to use or disclose protected health information for such research [this form has been so conditioned ___], or (2) for services conducted solely to produce information for a third party and the Authorization is for the disclosure of the protected health information to that third party [this form has been so conditioned ___]. This form has not been conditioned unless one of those two blanks has been checked. Also, if this is an Authorization, the Practitioner must provide you with a copy if you request one.

The information disclosed in this statement may potentially be subject to re-disclosure by the recipient, and at that time may no longer be protected by the HIPAA Privacy Regulation.

I understand that the release of this information is to permit my therapist to monitor my health status and to coordinate all the care that I may receive from general physicians, nurse practitioners, psychiatrists, physical therapists and other health care specialists or practitioners. This authorization can also apply to my permission to let my counselor speak to friends, family members, or another individual or agency of my choice. This authorization becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon.
If not otherwise indicated on the form, this authorization shall terminate automatically one year from execution.

I understand that the information authorized by this release will be provided to the authorized recipient(s) only. Additional information may be provided to this recipient only with signed authorization from me. I further understand that I have a right to receive a copy of this authorization upon request.

I have read and understand my rights pertaining to this Authorization/Release of Information Form.

_____ _____

Signature of Patient or Legal Guardian Date