



Consent for Release of Information

I, _____, hereby give permission for _____
at Light of the Rockies Christian Counseling Center to:

- request the following information from
- give the following information to:

| Name of Person | Phone Number |
|--|--------------|
| <input type="checkbox"/> Assessment Information | |
| <input type="checkbox"/> Treatment Plan | |
| <input type="checkbox"/> Treatment Progress | |
| <input type="checkbox"/> Diagnosis | |
| <input type="checkbox"/> Medication Management History | |
| <input type="checkbox"/> School Behavior and Academic Reports | |
| <input type="checkbox"/> Legal information | |
| <input type="checkbox"/> Psychiatric Assessments and Medication History | |
| <input type="checkbox"/> Social Services Treatment Plans or Intervention | |
| <input type="checkbox"/> _____ | |
| <input type="checkbox"/> _____ | |

I understand that any other information not stated above is confidential and will not be released without my consent. I understand that my records are confidential and will be used for professional purposes only. I furthermore release all parties here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise safeguards while using this information. Permission for such contact expires within 12 months of earliest date below.

Signature Date

Signature Date

Parent or Guardian Signature Date

Witness Date

921 E. Prospect Rd. Fort Collins, CO. 80525
970-484-1735 / 970-224-4893 fax

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