Consent for Release of Information

I,________________________________, hereby give permission for __________________________
Client Therapist

at Light of the Rockies Christian Counseling Center to:

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

____
Name of Person Phone Number

❑	Assessment Information	❑	Treatment Plan
❑	Diagnosis	❑	Treatment Progress
❑	Drug/Alcohol Abuse History & Discharge Summary	❑	Medication Management History
❑	School Behavior and Academic Reports	❑	Legal information
❑	Psychotherapy Notes (must be checked to release)	❑	Laboratory Test Results
❑	Psychiatric Assessments and Medication History	❑	Pertinent Information – Includes all dictated reports & lab results
❑	Social Services Treatment Plans or Intervention		
❑	____	❑	All Available Information

This information is to be used for:

- ❑ Aiding Treatment or evaluation
- ❑ Insurance Claim
- ❑ Other, please specify____

I understand that the records may include Drug/Alcohol Abuse information which is protected under the Federal Regulations governing confidentiality of Drug/Alcohol abuse patient records, 45 CRF, Paragraph 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. *See **#5** Redisclosure on back page.

1. **Right to Revoke:** I understand that I have the right to revoke the authorization in writing at any time subject to the exceptions stated below. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to **Light of the Rockies, 921 East Prospect Rd., Fort Collins, CO, 80525**

2. **Exceptions to Right to Revoke:** I understand that my written request to revoke this authorization will not affect the ability of Light of the Rockies to continue to use or disclose my information to the extent that it has already been acted in reliance of this authorization.

3. **Payment:** According to Colorado State Statutes, LOTR may charge reasonable fees for copies of medical records. Alternatively, we may provide you with a summary or explanation of your information if you agree to that, and to its cost, in advance. If you indicate above that you would like a summary of your information, we will inform you of the cost for that summary prior to providing you with the summary. If you do not agree to the charge, we will not prepare the summary.

4. **Potential for Redisclosure:** Your information which has already been disclosed according to this authorization will no longer be protected by the federal privacy law (known as “HIPAA”) and the recipient of the information may potentially redisclose it.

5. **Prohibition on Redisclosure of Drug/Alcohol Information:** The information that will be disclosed may contain records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit the receiving party from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of, the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

6. **Prohibition on conditioning of authorization:** We are prohibited from conditioning treatment on your signing this authorization unless; you are receiving research-related treatment; or the only reason Light of the Rockies is providing you with mental health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school.

7. **This authorization is binding:** The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the LOTR Mandatory Disclosure Statement.

Authorization must be signed by the client or by parent/legal guardian of a minor, or by the legal representative when the client lacks the decisional capacity, or if the client is physically unable to sign but mentally understands and consents.

I hereby authorize the use, or disclosure of my personal information described in this authorization. I understand that if anyone receives my information who is not a healthcare provider or a health plan, my information may not be protected by the federal privacy laws if the recipient rediscloses my health information.

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 signed. This statement of consent can be revoked in writing at any time before disclosure of the information. ***(This release is good until _________)***

Signature (Client must sign if 15 or older) Relationship to Client Date

Signature Relationship to Client Date

Proof of ID if necessary (Driver’s license #)

_______ I have received a copy of this document
Initials

Witness/Therapist Signature Date

5236 Strauss Cabin Road, Fort Collins CO, 80528
970-484-1735 call / 970-224-4893 fax