Insight Psychology, LLC

4611 Plettner Lane, Ste. 100
Evergreen, CO 80439

455 Sherman St., Ste. 140
Denver, CO 80203

720.443.3112

RELEASE OF INFORMATION

I authorize Insight Psychology, LLC to release protected information from my clinical record to the person(s) designated below.

I, _____, authorize Insight Psychology, LLC to obtain/release the following:

_____ Pertinent treatment information, including treatment, diagnosis, etc.

_____ Results of psychological assessment

_____ A copy of treatment records

_____ Other: _____

The information should only be obtained from/released to the following:

_____
Name (psychiatrist, physician, teacher, pastor, family member, etc.)

_____
Address, City, State, Zip

_____ _____
Telephone Fax

Authorization:
I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to Insight Psychology, LLC and that it will expire at the end of treatment involving me. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. **This authorization expires six month from date of client's or representative's signature below, unless otherwise specified:** _____. If I have authorized disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be valid as the original.

I understand that authorization disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee will be charged for any copy of my health record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the facility privacy officer or their designee.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Guardian Date

_____ _____
Witness Date