Diane Semerak, MA, LPC
Phone: 303-518-8949
981 Cowen Dr, Unit B4 **Carbondale, CO 81623**

Release of Information Consent

Client's Name: _____ DOB:_____

Address: _____ City: _____ State: Zip: _____

I, _____, authorize Diane Semerak, LPC, to send and receive the following identified information ☐ to and ☐ from (check as applicable):

Name (organization or individual): _____

Address:_____ City: _____,

State: _____ Zip: _____ Telephone: _____ Fax: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES

Please initial the items approved to be shared with or released to the party(ies) named above.

____ Medications prescribed
____ Progress reports
____ Summary reports
____ Personality profiles
____ *Psychotherapy Notes
____ Psychological reports
____ Service plans
____ Vocational testing results
____ *Entire record, except psychotherapy notes
____ Other, specify _____

The above information will be used for the following purposes (please initial all that apply):

____ Planning appropriate treatment or program
____ Continuing appropriate treatment or program
____ Determining eligibility for benefits or program
____ Case review
____ Updating files
____ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: ☐Self ☐Parent ☐Legal guardian ☐Other-_____. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client Signature: _____ Date:_____
Client or Parent/Legal Guardian of Client

Witness Signature: _____ Date: _____