Patti Ashley, Ph.D., L.P.C.

Authorization To Release/Request Information

Client:_____ **Date of Birth**:_____

I authorize

Patti Ashley to release copies of my records to:

_____
Name of Agency, etc.

_____
Address

_____
City, State, Zip

_____
Phone

_____
Name of Agency, etc.

_____
Address

_____
City, State, Zip

_____
Phone

to release copies of my records to Patti Ashley.

Specific Information To Be Released:

☐ Diagnosis ☐ Treatment Recommendations ☐ Treatment Summary ☐ Psychiatric History

☐ Psychological Testing/Consultations ☐ Admission History/Discharge Summary ☐ Educational Testing

☐ Physical Exam, Lab Studies, X-rays, EKG, EEG, Operative Reports

☐ Drug/Alcohol History & Treatment (must be specified)_____

☐ Other_____

List SPECIFIC Purpose for which information is to be released:

☐ Assessment ☐ Service Planning ☐ Continuity of Care ☐ Other_____

I understand I may revoke this authorization to release/request information at any time with written notice to Patti Ashley. Without such revocation, this authorization shall expire on _____ (Date), or if left blank, one year from the date of my signature. I also release Patti Ashley from all liability for releasing such information.

I understand that information to be released may include information regarding the following condition(s):

- Drug Abuse
- Alcoholism or Alcohol Abuse
- Psychiatric Conditions
- Auto-immune Deficiency (AIDS/HIV)

If the information to be released pertains to the diagnosis and treatment of alcoholism and/or drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42, CRS part 2.

_____ _____
Signature of Client/Parent/Guardian Relationship to Client

_____ _____
Witness Date

NOTICE TO WHOM THIS INFORMATION IS GIVEN: This information has been disclosed to you from records whose confidentiality is protected be Federal Law. Federal regulations prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains.

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