Authorization to Release/Exchange Confidential Information

Suzanne DeMontigny MA LPC
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(720) 317-3386

Client:_____DOB_____Date_____

Address:_____

I, the undersigned, hereby voluntarily authorize the exchange of information between the following providers and/or their authorized representatives of the following agencies/organizations as indicated. I understand that if the organization/agency authorized to receive the information is not a health care provider then Federal Privacy Regulations may no longer protect the released information.

Therefore, I, _____, do hereby authorize Suzanne DeMontigny, in accordance with Federal Regulation Part 1401, Title 21, of the code of Federal Regulations (37 C.F.R. 1401), and in compliance with Section 408 of Public Law 92-255 (21 U.S.C. 1175), to release or supply from the below listed, the following information from my treatment records:

____ Any and All Information Necessary
____ Diagnosis ____ Treatment Plan ____ Prognosis
____ Progress to Date ____ Clinical Assessment Results ____ Dates of Treatment
____ Patient Records ____ Summary of Treatment
____Other_____

Names and addresses of sources to request/obtain information:
1.
2.
3.

Names and addresses to release information:
1.
2.
3.

I understand that I have a right to receive a copy of this authorization. I may revoke this consent at any time. This consent is in effect only for five years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in the client informed consent/disclosure form.
I hereby release the above parties from any and all liability for exchanging this confidential information.

_____ _____
Client Signature Date