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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____(DOB)_____, hereby authorize Craig D. Lounsbrough, M.Div., LPC to release to and/or receive from: (Example: a former therapist, your current Medical Doctor or psychiatrist), my confidential medical and psychological information and records. Information relative to my counseling and/or psychological evaluation, including: psychological test reports, social history summary, medical records, including medications received, counseling records, or other. Information and records released to Craig D. Lounsbrough are for the purpose of: _____ _____.

Information released includes but is not limited to: dates of contact, reasons for treatment, issues around fitness to parent, relationships with any and all significant others, diagnosis, and treatment progress and outcome. Please list the following information regarding who you are releasing me to contact.

Name: _____

Address: _____

Phone #: _____

I understand that disclosure of this confidential medical record information is protected by HIPAA Federal Regulation 42 CFR, Part 2, and Colorado Revised Statutes 25-1-802 and federal law protects that further disclosure and no further disclosure will be made without my specific and written permission. I further understand that my information may not be protected from re-disclosure by the recipient of this information. The recipient (s) may not re-disclose any information without my further written authorization unless otherwise provided for by state or federal law.

I understand that a copy or facsimile of this authorization is to be considered as valid as the original and that with this authorization I give permission for this information to be sent, either by FAX 303-840-0902 or by regular surface mail. I understand that I may withdraw this authorization, in writing, at any time and that any action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____
Signature of Patient (or parents/guardian if minor) Please Print Your Name Here/ Date

_____ _____
Signature of Partner (If in conjoint therapy) Please Print Your Name Here/ Date

_____ _____
Witness Date