Stephanie Roberts LPC, CACIII
3393 Iris Ave Ste. # 204
Boulder, CO 80301

AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION

I, _____, hereby give permission to Stephanie Roberts and billing to
Name of Client

____Disclose
____Obtain
____Exchange

Information in written and/or verbal form to/from/with:

_____
Name of Insurance Company, agency, attorney, school counselor, therapist etc…

_____
Address phone/Fax

SPECIFIC INFORMATION TO BE DISCLOSED:
____Psychological records, including assessment and evaluation
____Medical records to include Alcohol and/or Drug abuse Information/HIV related information
____Other (Specify):_____

I understand that the information to be exchange includes information regarding psychological or psychiatric conditions as well as health and medical conditions. I understand that this information will be used for coordination of care, or for treatment, evaluation, insurance or legal purposes by the outside agency or person.

I certify that this request for authorization has been signed voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it.

_____ _____
Signature of client Date

_____
Signature of Parent, Guardian, Conservator, or Authorized representative Date

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Witness
