7851 South Elati, Suite 203
Littelton, CO 80120
(720) 295-8010

Release of Information Form

This form, when completed and signed by a client, authorizes Colorado Anger Solutions (CAS) to release protected information from the client's clinical record to the person designated.

I, ______________________________ (print name), authorize CAS to release or obtain the following information (describe the information you want shared; be as specific & detailed as possible):

____

____

This information should only be released to or obtained from (name, address and phone number of the person to whom the information is to be shared):

____

____

____

I am requesting CAS to release or obtain this information for the following reasons: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)

____

____

This authorization shall remain in effect until six months of the date signed below or until (fill in an event that relates to the individual or the purpose of the use or disclosure):

I understand I have the right to revoke this authorization, in writing at any time by sending such written notification to the Colorado Anger Solutions address. However, the revocation will not be effective to the extent that Colorado Anger Solutions has taken action in reliance on the authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and is no longer protected by the HIPAA Privacy Rule.

____ __________________
Signature of Client/Representative Date

____ __________________
Signature of Witness Date

If the authorization is signed by a personal representative of the client (e.g., Parent), a description of such representative's authority to act for the client must be provided here: ___________________________