Center for Compassion
Strengthening Relationships
Carema Cook-Masaud 720.480.6633

AUTHORIZATION TO RELEASE OR REQUEST INFORMATION

Date: _____

I, _____ (your name), hereby authorize Carema Cook Masaud, MA, LPC to release___ and/or request___ the following information concerning me

from or to: (Name of person, therapist, hospital, agency, company or other)

_____

Street Address (of therapist, agency etc.):

_____

City, State and Zip Code: _____

Telephone and/or Fax: _____

The disclosure of information and record authorized herein is required for the following purpose(s):

Legal ___ Medical ___ Therapeutic ___ Psychiatric ___

Psychological ___ Education ___ Other: _____

The specific type(s) of information to be disclosed are as follows:

All Records ___ Admission and discharge summaries ___

Presence in treatment ___ Treatment Plan ___

Verbal progress ___ Written progress ___

Other: _____

This authorization shall remain valid until what date: _____

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that this information may not be released to or received from any other person or organization without my permission in writing. A photocopy or scan of this authorization shall be considered valid. The information disclosed and/or requested shall not be used for any purpose other than its intended use. I hereby release Carema Cook-Masaud, Center for Compassion and the above listed party from liability that may result from furnishing this information.

Date and Signature of Client or Responsible Party:

_____ Date: _____