Authorization for Release of Behavioral Health Information

Information Regarding:

Name:_____ Date:_____

Address:_____ City:_____ CO, zip:_____

Phone:_____ email:_____

I agree that Christa Kay Clarke has permission to discuss and/or disseminate confidential behavioral health information to and receive from:

Name:_____

Address:_____City:_____CO, zip_____

Phone:_____ email:_____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to CK Counseling, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my behavioral health information, I can contact the CK Counseling, LLC.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ X_____

Client/Parent/Guardian Signature Date