



C. Blair Skinner, M.S.
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Authorization to Release Information

I, _____,
(client's/parent's name)

authorize the mutual exchange of information
between C. Blair Skinner, M.S., LMFT and _____.
(name of person or organization)

Information to be released includes: (check boxes)

- | | |
|--------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Social History | <input type="checkbox"/> Legal History |
| <input type="checkbox"/> Psychological Reports or Evaluations | <input type="checkbox"/> Treatment Goals |
| <input type="checkbox"/> Psychiatric History | <input type="checkbox"/> Medical History |
| <input type="checkbox"/> Other _____. | |
| <input type="checkbox"/> Protected Health Information (if checked, this must be a consent for release of PHI only) | |

Information is released for the purpose of: (check boxes)

- | | |
|---------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Continuity of Care | <input type="checkbox"/> Assessment |
| <input type="checkbox"/> Service Planning | <input type="checkbox"/> Legal Purposes |
| <input type="checkbox"/> Other _____. | |

I understand that my records are protected under specific federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it (e.g. the provision of treatment upon consent to disclosure to third party players) and that in any event this consent expires automatically as described below.

This authorization of exchange of information is valid for one year from date of signature.

I understand that information used or disclosed pursuant to this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by the HIPPA privacy rule.

I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

Printed name: _____

Signature: _____

Date: _____

Therapist's Signature: _____

Date: _____

