COUNSELING CENTER
AND PSYCHOLOGICAL SERVICES
1106 N. Cascade Avenue, Colorado Springs, CO 80903
Phone: (719) 389-6093 Fax: (719) 389-6064

COLORADO COLLEGE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Local Phone: _____
CC ID#: _____ Date of Birth: _____

To Release and Exchange Records Between:

Colorado College Counseling Center & Psychological Svcs.
1106 N. Cascade Avenue
Colorado Springs, CO 80903
Phone: (719)-389-6093
Fax: (719) 389-6064

Name:_____
Address:_____
City/Zip:_____
Phone: _____
Fax: _____

I request and authorize the Colorado College Counseling Center and Psychological Services to release and exchange the information specified below to_____.

- ☐ Complete Health Records
- ☐ Drug or alcohol abuse, or history, if any
- ☐ Information regarding HIV and/or HIV test results
- ☐ Psychological or psychiatric conditions, or history, if any
- ☐ Information regarding learning disability and/or attention deficit disorder, if any
- ☐ Progess Notes
- ☐ Laboratory Tests
- ☐ Consultation Reports
- ☐ Treatment Summary
- ☐ Other (please specify): _____

Covering the period of health care:
From (date): _____ To : _____

The reason I am requesting this information is: ___Coordination of Treatment and Continuity of Care_____
_____

Client/Patient Rights:

I certify that this request has been made voluntarily. I understand that information about my case is confidential and protected by state and federal law. I understand that this authorization will expire 180 days from the date of my signature. I may revoke this authorization by writing a letter to the releasing office/health center. If I do, it will not affect any actions already taken by the above named practice based upon this authorization.
Once the office/health center discloses health information, the person or organization that receives it may re-disclose it. I understand what this agreement means, and that I am entitled to a copy of this form. A copy or fax of this release is as valid as the original.

_____ _____
Client/Patient Signature Date