Heather Carroll, PsyD, PLLC

2121 South Oneida St. Suite 240 - Denver, CO 80224

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AUTHORIZATION TO RELEASE INFORMATION

I (we), _____ (**name of client or caregiver**) authorize Dr. Heather Carroll to release and obtain information regarding **(name of client)** _____, (hereinafter "Client"), whose date of birth is _____. I authorize Dr. Carroll to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, therapist's diagnosis of Client.

To and From: _____
Name/Organization_____
Address_____
Phone number_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Dr. Carroll has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Dr. Carroll at 2121 South Oneida St., Suite 240, Denver, CO 80224 to be effective.

The information or records to be released or disclosed include:

_____ Initial Evaluation/History
_____ Psychiatric/Psychological Reports
_____ Medical Information
_____ Therapy Notes
_____ Billing Records
_____ Transfer/Termination Summary
_____ Tests Taken and Testing Scores
_____ Other (specify): _____
_____ Any and all records/Information

Dr. Carroll shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Colorado law may protect such information.

_____	_____	_____
Client's Name (Print)	Client's Signature (If 15 or Older)	Date
_____	_____	_____
Name of Parent(s) (Print)	Signature of Parent(s)	Date
_____	_____	
Heather Carroll, Psy.D., PLLC	Date	