Meredith Wakelyn, LCSW
1855 S. Pearl Street Suite 20
Denver, CO 80210
720.371.1882

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____, hereby authorize Meredith Wakelyn, LCSW
Client
and ____, at ______________________ to
Name **Telephone**
exchange information.

The type of information to be disclosed:
Evaluations______ Medical/Hospital Records______ Diagnosis______ Psychological/Medical Test Results______ Treatment Plan______
Mental Health Record Summary______ Course of Treatment______
Psychotherapy Notes______
Other ____

The purpose of such disclosure:
Ongoing Treatment______ Medical Care______ Consultation ______ Evaluation______
Transfer______ Legal issues______ Coordination of Care______
Health Benefit Utilization ______ Other ________
Exceptions: ____
____

The designated information about me ( ) may ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms.

Meredith Wakelyn, LCSW and the above designated person ( ) may ( ) may not discuss by telephone the content of the information released. This consent is in effect until ________________________.
date

I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place. I hereby release all parties stated herewith from any liability resulting from the release of this information.

I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or

others, and to abuse or neglect of children. I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

____ ____________________
Signature of Client **Date**

____ ____________________
Signature of Therapist **Date**

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION