AUTHORIZATION TO RELEASE AND EXCHANGE MEDICAL AND MENTAL HEALTH INFORMATION

PROVIDER: Barry Erdman, LCSW, DCSW
1900 Folsom Street Suite 203
Boulder CO 80302
303 444-1404/fax: 303 444-3491

PATIENT:
ADDRESS:
SS#:
DOB:

I request and authorize the above-named mental health care provider and _____ located at _____ to release and exchange information specified below. I understand that the information to be released may include information regarding the following condition(s):

_x_ Drug abuse, if any
_x_ AIDS or HIV, if any
_x_ Alcoholism or alcohol abuse, if any
_x_ Psychological or psychiatric conditions, if any

Information that may be released:

___Copy of provider's complete office and treatment charts including all correspondence, test results, notes, reports, and billing records
___ Summary of evaluation and/or treatment
___ Verbal communications with the provider regarding evaluation and/or treatment
___ Administrative records, including but not limited to billing, dates of service and referral information.
___ Psychotherapy notes.
___ Other (specify): _____

Dates Covered:

___ All admissions or care
___ Limited to treatment dates or conditions (specify):_____
_____

Purpose(s) or need for which the information is to be used:

___ To obtain information for decisions related to providing or coordinating service.
___ Other (specify): _____

AUTHORIZATION: I hereby acknowledge that this release has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. This authorization may be used or reused to obtain subsequently prepared records pertaining to treatment of any type after the date of this release as long as this authorization remains valid. This authorization shall be valid for one year from the date of my signature. I understand that when this information is released it may no longer be protected by the HIPAA Federal Privacy Regulation. I also hereby acknowledge that treatment, payment, or eligibility for benefits were not conditioned on my signing this authorization.

OTHER CONDITIONS: _x_ A copy or facsimile of this authorization may be used with the same effectiveness as the original.

X_____ _____
PATIENT or PERSON AUTHORIZED TO SIGN FOR THE PATIENT — DATE

_____
(Print name. If not the patient, state how authorized.)