Barry Erdman, LCSW, DCSW • Licensed Clinical Social Worker
1900 Folsom St Ste 203 • Boulder CO 80302-7523
303 444-1404 • 303 444-3491 (fax)
be@BoulderTherapist.com • www.BoulderTherapist.com

AUTHORIZATION TO RELEASE MENTAL HEALTH INFORMATION

I hereby authorize Barry Erdman, LCSW, DCSW, to release information specified below
to: _____
_____
_____

Regarding the treatment of:
_____ _____
(Name) *(Birth Date)*

I understand that the information to be released may include information regarding the following condition(s): Drug abuse, Alcoholism or alcohol abuse, AIDS or HIV, Psychological or psychiatric conditions, if any.

Information to be Provided:
- ❑ Copy of complete office & treatment charts including all correspondence, test results, notes, reports, and billing records.
- ❑ Summary of evaluation and/or treatment
- ❑ Verbal communications with the entity listed above regarding evaluation and/or treatment
- ❑ Administrative records, including but not limited to billing, dates of service and referral information
- ❑ 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 disclosed:
- ❑ To provide information for decisions related to providing or coordinating services.
- ❑ Other (specify): _____

AUTHORIZATION: I hereby acknowledge that this request 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 provide 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: 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)