

Ponderosa Counseling Center
19753 E Pikes Peak Ct, Suite 202
Parker, CO 80138
Phone: (720)542-3487 Fax: (720)542-3566

Patient Name _____ Date of Birth: __/__/__

I, _____, hereby authorize the mutual exchange of
(Please print the name of patient or representative.)

information between Ponderosa Counseling Center and the following:

(Name of hospital, physician, clinic, school, teacher, etc.)

(Address of hospital, physician, clinic, school, teacher, etc., including city, state and zip code.)

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(Phone number) (Alternate phone number) (Fax Number)

I understand that information to be released for the purpose of psychiatric evaluation and ongoing treatment may include information regarding the following conditioning(s):

- Psychiatric Conditions, Psychological Testing, Progress Notes, Medications Prescribed
- Assessment including Diagnosis
- Treatment Summary, Recommendations, Consultation
- Drug and/or Alcohol Abuse
- Medical Information
- HIV (Human Immunodeficiency Virus)/AIDS(Acquired Immunodeficiency Syndrome)
- Educational Information

I understand that I may revoke this consent to release medical information at any time by giving written notice to Ponderosa Counseling Center except to the extent that action has already been taken to comply with it. Without such revocation, this consent is valid until treatment with Ponderosa Counseling Center ends.

I release Ponderosa Counseling Center from all legal responsibility and liability for the information released according to the terms of this written consent. I understand that there is the potential for this protected health information to be re-disclosed by the recipient and thus no longer protected under the HIPPA privacy rule.

Signature of Patient _____ Date __/__/__

(if 15 years or older)

Signature of Parent or Legal Guardian _____ Date __/__/__

Relationship to Patient _____

Signature of Witness _____ Date __/__/__

A Photocopy or Fax of this Document shall be as effective as the Original