Ponderosa Counseling Center
19753 Pikes Peak Ave.
Parker, CO 80138
Phone: (720) 542-3487 Fax: (720) 542-3566

Patient Name_____ Date of Birth: ___/___/___

I, _____, hereby authorize the mutual exchange of information between the following Ponderosa Counseling Center Group Practitioners in the case of covering for one another's clients when practitioners are on vacation or leave; and/or when client's cases are shared between medication provider and therapist.

The following Ponderosa Counseling Center Group Practitioners are:

Laurie Reeder, PMHNP
Psychiatric Mental Health Nurse Practitioner

Deb Collins, PMHNP
Psychiatric Mental Health Nurse Practitioner

K.C. Cullen, PMHNP
Psychiatric Mental Health Nurse Practitioner

Maki Sonoda-Sutton, MA, LPC
Licensed Professional Counselor

I understand that information to be released for collaboration, coordination of care and ongoing treatment may include information regarding the following conditioning(s):
-Psychiatric Conditions, Psychological Testing, Progress Notes, and Medication Prescribed
-Assessment including Diagnosis
-Treatment summary, Recommendations and 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 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