BraindropsPlayTherapy.com

Playful Emotion Family Center
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Fort Collins, CO 80524
(970) 818-0882

Authorization For Release of Information

I, ________________________________, hereby authorize Braindrops Play Therapy & Wellness LLC to to exchange information, regarding myself or my child ______________________________, with the people or organizations listed below:

Names and/or Organizations:
Telephone: Email Address:

I authorize the disclosure of the following type of information:

Therapeutic Observations, including a summary of mental health sessions

Recommendations and potential supports

Diagnostic data and results

Other:

The purpose of such disclosure is as following:

Ongoing Treatment | Medical Care | Evaluation | Transfer
Other: | Legal issues | Coordination of Care

Exceptions:____
The designated information about me ( ) may ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Braindrops Play Therapy & Wellness LLC, and the above designated person ( ) may ( ) may not discuss by telephone the content of the information released.

This consent is in effect for one year unless otherwise indicated__________________________. 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, 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 assault 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 or Parent/Guardian Date

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