



Columbine Counseling Center

OFFICIAL RELEASE OF CONFIDENTIAL INFORMATION

Date: _____

Client Name: _____ Date of Birth: _____

I hereby authorize Columbine Counseling Center P.C. to:
(Check either or both boxes)

obtain information from

release information to

_____ (Agency)
 _____ (Attention)
 _____ (Street Address)
 _____ (City, State, Zip)
 _____ (Phone Number)

The specific materials requested or to be released are listed below:

- | | |
|---|---|
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Dates of Treatment Only |
| <input type="checkbox"/> Laboratory Data | <input type="checkbox"/> Psychological Test Records |
| <input type="checkbox"/> Progress Reports | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Summary of Treatment | <input type="checkbox"/> Educational/School Records |
| <input type="checkbox"/> Other: _____ | |

I understand that the information to be released may include material that is protected by state and/or Federal Regulations 42 C.F.R., Part 2, applicable to either mental health or drug/alcohol abuse or both. My signature authorizes release of all such information as specified above.

Columbine Counseling Center, P.C. is not responsible for any information forwarded to other parties once it is released.

This release is in effect for 90 days from _____ unless otherwise specified.

Signature of Parent/Guardian

Witness

Signature of Parent/Guardian