SARAH FREEZE, LCSW

Psychotherapist & Consultant

1221 S Clarkson St, Suite 206
Denver, CO 80210
(303) 704-8006
sf@sarahfreezelcsw.com

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, ___________________________________, whose Date of Birth is _______________, authorize Sarah Freeze, LCSW to disclose to and/or obtain from:

____
Name of Person, Title, and/or Organization

____
Address

____
Phone and fax numbers

Authorization to release the following specific information only:

___ Verbal summary and discussion of treatment

___ Record of attendance only

___ Evaluations/Testing reports

___ Treatment summary

___ Complete Medical/Mental Health record

___ Treatment plan

___ Diagnosis/Psychiatric conditions

___ Drug/Alcohol abuse information

___ Psychotherapy Notes

___ Other:

____

The purpose of this release is:

___ Coordination of care

___ Treatment planning

___ Legal issues

___ Testing/assessment

___ Condition of court order/parole

___ At the request of the client

___ Other: ____________________

Exceptions:

The authorization will remain in effect until:

___ Revoked by me in writing

___ Date (fill in an expiration date/event that relates to the individual or purpose of the

disclosure). ____________________________

You have the right to revoke this authorization, in writing, at any time by delivering such written notification to Sarah Freeze, LCSW, LLC at 1221 S Clarkson St, Suite 206, Denver, CO 80210. Please note that your revocation will not be effective to the extent that action has already been taken in reliance of this authorization or if this authorization was obtained as a condition of obtaining insurance coverage.

Sarah Freeze, LCSW, LLC will not condition your treatment on whether you give authorization for the requested disclosure.

Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that this form, when completed and signed by me, authorizes professionals with Sarah Freeze, LCSW to release verbal information or written information from my records to the person/organization designated above. I understand that this may contain references to mental health, treatment progress and/or prognosis:

____ ___________________________ Signature of Client/Patient Date

____ ___________________________ Signature of Parent, Guardian or Personal Representative Date