GROUND COUNSELING

REX D WEST, MA, LPC

REX WEST, MA, LPC (# 0012679), 4774 MCKINLEY DRIVE, BOULDER, COLORADO 80303, 303.945.3861

Request/Authorization to Release Confidential Records and Information

I hereby authorize: **Rex D West, Ground Counseling**
Address: **4774 McKinley Drive, Boulder, Colorado 80303**

Phone: **303.335-7822**

to release information from records about _____, born on _____ , and

whose Social Security number is _____, for the following purpose(s):

❑ Further mental health evaluation, treatment, or care ❑ Rehabilitation program development or services
❑ Treatment planning ❑ Research ❑ Other: _____

These records concern the time between _____ and _____
In the boxes below, the information to be disclosed is marked by an X, the items not to be released have a line drawn through them and, page numbers are indicated when appropriate. Written dates indicate when those records were mailed to the requester.

❑ Intake and discharge summaries _____ ❑ Medical history and evaluation(s) _____

❑ Mental health evaluations _____ ❑ Developmental and/or social history_____

❑ Educational records _____ ❑ Progress notes, and treatment or closing summary _____

❑ Other: _____ _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: X Do not release HIV-related information ❑ Do not release drug and alcohol information.

These records will be released to

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____ _____ _____

Signature of client | Printed name | Date

_____ _____ _____ _____

Signature of parent/guardian/representative | Printed name | Relationship | Date

❑ Copy for patient or parent/guardian ❑ Copy for source of records ❑ Copy for recipient of records