KATHY HIGGINS LPC LLC
LITTLETON COLORADO 80128
PHONE: 720-663-7702
FAX 303-948-1998

CONSENT FOR RELEASE OF INFORMATION

I _____ hereby authorize the exchange of information between

_____ of KATHY HIGGINS LPC LLC and:

Name: _____

Address: _____

_____

Phone: _____

The type of information to be disclosed is:

❒ Medical/Mental Health Records
❒ Mental Health Treatment Summary
❒ Evaluations
❒ Diagnosis
❒ Course of Treatment
❒ Treatment Plan
❒ Psychological/Medical Test Results
❒ Other_____

For the purpose of:

❒ Ongoing Treatment
❒ Coordination of Care
❒ Health Benefit Utilization
❒ Evaluation
❒ Medical Care
❒ Transfer
❒ Consultation
❒ Legal Issues
❒ Other_____

Exceptions:_____

This consent is in effect until either the following date or event:_____, at which time this release will expire. I understand that I may revoke the consent, in writing, at any time, except to the extent that action based on it has already taken place.

I understand that the designated information about me may be sent by mail or delivery service, transmitted by fax, electronic mail or other electronic file transfer mechanism, or exchanged verbally unless otherwise restricted by me.

I understand that I have the right to request restrictions on uses and disclosures of protected health information. Kathy Higgins, LPC, LLC, is not required to agree to this request, but if we do agree, the restriction is binding and will be honored. I understand that Kathy Higgins, LPC, LLC has a formal NOTICE OF PRIVACY PRACTICES containing additional information and that I may review the notice prior to signing the consent. The NOTICE OF PRIVACY PRACTICES may change from time to time and I may obtain a revised notice from my therapist.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy or fax of this release shall be as valid as the original.

_____ _____ _____ _____
Signature of Client (ages 15 and older) Date Parent/Guardian Signature (under age I5) Date

_____ _____
Therapist or Witness Signature Date

NOTICE TO RECIPIENT: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. It may also be covered under 42 CFR Part 2, "Confidentiality Of Alcohol And Drug Abuse Patient Records." Federal regulations prohibit you from making any further disclosures of this information except with the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

This consent has been revoked by the client effective _____.

Recorded by: _____ Date