Boulder Center for Cognitive and Behavioral Therapies
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# AUTHORIZATION FOR RELEASE/REQUEST/EXCHANGE OF INFORMATION

I request and authorize Alisha Brosse, PhD, Monika Hauser, PhD and/or other agents of the Boulder Center for Cognitive & Behavioral Therapies LLP to __ RELEASE, __ REQUEST, or XX EXCHANGE information (in written or verbal form) regarding

_____
Client's name Date of Birth

to/from/with _____
Name of Person/Agency/Organization/Physician

_____
Address

_____ _____
Phone Fax

I understand that the information to be exchanged includes information regarding:
XX Psychological or psychiatric conditions, if any
XX alcohol/substance use, if any
XX Health related conditions, if any
___ Other: _____

I understand that the information exchanged will be used to:
XX Provide continuity/coordination of care
XX Aid in evaluation and treatment
___ Other: _____

I certify that this request and authorization has been made voluntarily. I understand that I may revoke this authorization at any time, and that it will automatically expire 3 months after my treatment ends. Redisclosure of my records by those receiving the authorized information is prohibited. I hereby release both of the above parties from any liability which may result from furnishing the information released, requested, or exchanged.

Signature of client_____ Date_____