

Psychological Services Center University of Colorado Denver

1200 Larimer Street
North Classroom Suite 3002
Campus Box 173
Denver, CO 80217
Phone: 303-556-5289 Fax: 303-556-6108

Authorization to Release or Request Information

Date: _____

I, _____, hereby authorize the staff of the UCD Psychological Services Center to release and/or request the following information concerning me **TO** and/or **FROM**:

(Name of person, hospital/agency/company)

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

The disclosure of information and records authorized herein is required for the following purpose:

- | | | |
|--------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Education | <input type="checkbox"/> Legal | <input type="checkbox"/> Medical |
| <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Psychological | <input type="checkbox"/> Other: _____ |

The specific type(s) of information to be disclosed are as follows:

- | | |
|---|--|
| <input type="checkbox"/> All records | <input type="checkbox"/> Admission and discharge summaries |
| <input type="checkbox"/> Presence in treatment | <input type="checkbox"/> Treatment plan |
| <input type="checkbox"/> Verbal and/or written progress | <input type="checkbox"/> Other: _____ |

This authorization shall remain valid until: _____

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that this information may not be released to or received from any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid. The information disclosed and/or requested shall not be used for any purpose other than its intended use. I hereby release the UCD Psychological Services Center and the above listed party from liability that may result from furnishing this information.

Signature of Patient or Responsible Party

Date

Signature of Witness

Date