Request for Release of Confidential Medical Records

I, or legal guardian of, ________________________________(client), DOB: ____________ request that my medical records are released/exchanged/received from and/or to:

and disclosed/exchanged with/to: **River View Counseling, pllc**
P.O. Box 678
Kremmling, CO 80459
Phone: 970-531-1996 Fax: 970-557-3170

For the purpose of:

Information to be released/exchanged/received:

Dates of Service
Laboratory results
Treatment progress
Discharge summary
Treatment summary (incl. dates of service, diagnosis, goals, progress and recommendations)
Diagnoses

Participants
Treatment Goals
School reports: grades, behavior, IEP
Clinical Opinion/impressions
Model of Therapy utilized
Other: _____________________

Treatment Recommendations and supporting information
Substance abuse, use and treatment
Other: _____________________

This Request for Release of Information was initiated on ________________ and expires on ________________.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon, and in any event, this consent expires automatically one year from the date signed.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 and 164. I also understand that this confidential medical record information is protected by Colorado Revised Statutes 24-72-202 (4) and 27-10-120. This information cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in one year.

I also understand that this information is or may be protected by federal regulations and hereby release River View Counseling, pllc, Mary Entrican, and the individual or institution named above from any liability associated with the release of this information. I understand that signing this release of information is not a condition of receiving treatment.

Client Name (printed): ____ **Date:** ____________

Client Signature: ____

Guardian/Parent Name (printed): ____

Guardian/Parent Signature: ____

Witness Name (printed): Mary Entrican, MS, LMFT, CAC II

Witness Signature: ____ **Date:** ____________
Title: Licensed Marriage and Family Therapist and President/Owner

Updated 4-2014 ***If document is submitted via email, confidentiality cannot be assured*** Chart #: