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Licensed Clinical Psychologist
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Authorization for Release of Information

I, _____, date of birth_____,

hereby authorize Dr. Brenda K. O'Reilly and _____

at_____(phone), _____(address)

to exchange information.

The type of information to be disclosed includes any applicable behavioral health and/or treatment information, including diagnosis, treatment summary, prognosis, and medications.

The purpose of the disclosure is to ensure quality and coordination of care.

This consent is in effect until_____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

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

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of a licensed psychologist, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault and neglect of children.

This is to certify that I have given consent voluntarily and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Signature_____Date_____

Signature of legal guardian (if applicable)_____

Relationship to client_____Date _____