LAVENDER
MENTAL HEALTH
160 E 12th St. Ste 1
Durango, CO 81301
970.426.0636

Release of Information

Authorization for the use and disclosure of Protected Health Information (PHI) is only for the person or agency identified on this form. Release will expire two years after the signature date or 45 calendar days after treatment is terminated, whichever is first.

Client Name:	DOB:	Today's Date:

I, _____ ,authorize Lavender Mental Health, whose office is located at 160 E 12th Street, Ste. 1, Durango, CO, 81301 to release and exchange by phone, fax, email or mail my PHI with _____.

Reason/Purpose for Disclosure: (please circle)

Collaboration
Insurance/Payment
Continued Care/Treatment
Request of client
Legal
Other:

The PHI to be disclosed includes the following: (please circle)

Assessment/Intake Information
Diagnosis
Treatment Plan
Progress & Treatment Notes
Medication
Recommendations
Results of Psychological Testing
Psychiatric Evaluation
Reasons for Termination
Other:

Notes:

By signing below, I acknowledge that the above information about me may be released, discussed, or disclosed. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to my therapist/clinical social worker.

_____ _____ _____
Client Signature Date Print Name

_____ _____
Therapist/Provider Signature Date