RELEASE OF INFORMATION

Cecilia Kosak, LMFT/ATR
Art at Heart Psychotherapy, LLC
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303-902-0060 - www.artatheartpsychotherapy.com - Cecilia@artatheartpsychotherapy.com

I _____, hereby consent and authorize Cecilia Kosak to:

☐ **Release to:** ☐ **Obtain from:**

_____
Name of individual, institution

_____
Address (city/state/zip) *Telephone Number*

The following types of information:

☐ Discussions about the client that are pertinent to our therapeutic work together including:
- Psychological, drug, behavioral, and health history
- Current information about client drugs, psychological health, behaviors, and diagnoses

☐ Other:
_____

For the following purposes:
❑ Coordination of care ❑ Diagnostic information ❑ Safety planning
❑ Other_____ _____

I understand that this consent becomes effective on the date I sign it, and will continue in effect for the duration of my therapeutic work with Cecilia Kosak unless I revoke it before that time. I understand I have the right to revoke this authorization by notifying Cecilia Kosak of my desire to do so. I understand that I am entitled to receive a copy of this authorization upon request. I agree that a photocopy or facsimile copy of this signed authorization form is as valid as an original signed copy. I understand that after this information is disclosed, federal law might not protect it, and the recipient might re-disclose it. I agree to release the above named individual(s) or organization(s) and the Cecilia Kosak, from liability that may result from furnishing this information as authorized in this disclosure. I have had the opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

If you are a Personal Representative signing on behalf of the client, circle which of the following roles warrants you the authority to sign this form: health care Power of Attorney (copy attached); court ordered Conservator or Guardian (copy attached): Parent of unemancipated minor child: other:_____.

_____ _____
Signature of Client/ Personal Representative (circle one) **Date**

_____ _____
Cecilia Kosak Signature **Date**

To recipient of these records:
This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Pt. 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute the client.