Authorization for Release of Information

By initialing and signing, I authorize that Cottonwood Creek Counseling and the individuals and entities listed below may mutually disclose and release my personal health information for the purpose of payment, diagnosis, treatment, coordination of care, and other therapeutic purposes. This may involve the exchange of any records including assessments, reports, clinical test results, professional opinions, and all information relating to psychological, medical, educational, and any other pertinent information. I understand that a photocopy or facsimile of this consent shall have the same effect as the original.

Upon request, I may revoke this authorization at any time by sending a written notice to Cottonwood Creek Counseling. Any disclosures that have been made to the individuals or entities listed below prior to this written notice however will not be affected by the revocation.

I understand that the information used in this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by the confidentiality regulations of Cottonwood Creek Counseling. In listing individuals and entities below, I waive my right of privacy of information disclosed that is hereby authorized. This authorization is only valid during treatment at Cottonwood Creek Counseling and up to three months after termination or completion of treatment. I understand that if I wish to have information from my personal file disclosed after this time period, a new authorization will need to be completed and I may be charged a $25 fee to access closed files.

Name/Entity	Address/City	Phone	Initial
Insurance:			
Medical:			
Other:			
Other:			
Other:			

______________________________ Print Name of Client or Responsible Party
______________________________ Signature of Client or Responsible Party
______________ Date

______________________________ Print Name of Client or Responsible Party
______________________________ Signature of Client or Responsible Party
______________ Date

______________________________ Print Name of Witness
______________________________ Signature of Witness
______________ Date

Parent/Guardian Authorization for Treatment of Minor: (as applicable)

I authorize that my child ______________________ (Date of Birth: ____________) may engage in services provided by Cottonwood Creek Counseling. I understand that I am giving consent for my child to meet one on one with the therapist and also agree that parental involvement may be required during the course of treatment including: family counseling, parenting skills training, co-parenting sessions, and the therapist's exchange of information with the other parent.

______________________________ Print Name of Parent 1
______________________________ Signature of Parent 1
______________ Date

______________________________ Print Name of Parent 2
______________________________ Signature of Parent 2
______________ Date