FABLED COUNSELING
Shaun Hutto, MA, NCC, LPC, EMDR, CSAT

2922 Evergreen Parkway, Suite B204
Evergreen, CO 80439
(720) 507-8956

4800 W. 80th Ave. #201
Westminster, CO 80030
(720) 507-8956

AUTHORIZATION TO RELEASE INFORMATION

I, _____, (hereinafter "Client") hereby authorize Shaun Hutto, (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, therapist's diagnosis of Client, to:

_____
(name of person/entity authorized to receive info)

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 4800 W. 80th Avenue, #210, Westminster, CO 80030 to be effective. This disclosure of information and records authorized by Client is required for the following purpose:

_____
(reason for release)

The specific uses and limitations of the types of medical information to be discussed are as follows (*be as specific as you choose to*):

- ☐ Presence in Treatment
- ☐ Discharge Summary
- ☐ Treatment Plan/Recommendation
- ☐ Copy of Aftercare Plan (if applies)
- ☐ Criminal Justice History
- ☐ Probation/Parole Conditions
- ☐ Verbal and Written Progress
- ☐ Educational Information
- ☐ Psychosocial History
- ☐ Psychiatric History
- ☐ Psychological Evaluation
- ☐ Medication History
- ☐ Physician's Orders
- ☐ Other_____

I understand that information to be released may include information listed above and/or information regarding the following:

- ☐ Chemical Abuse and/or Dependency
- ☐ Criminal Records
- ☐ HIV/AIDS Testing or Status
- ☐ Psychiatric Conditions
- ☐ Judiciary Recommendations
- ☐ Other _____

Provider shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form. I certify that this request has been made voluntarily. Client understands that he/she may revoke this authorization at any time, except to the extent that action has been taken to comply with it. Client hereby releases any other service provider or individual from any liability, which may result from furnishing the information requested as authorized in this release.

The Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

This authorization shall remain valid until: _____
valid until date

_____ _____
Client Signature *Date*

_____ _____
Therapist Signature *Date*