MARIAN SALLEY LCSW, LAC, CGP, ACS
LCSW CA # 100609
LCSW CO # 9923757
LCSW MT # 36955
LCSW OK # 6733
LAC # 1041
CGP # 58884
ACS # 2823
EMDRIA Certified EMDR Therapist
2299 Pearl Street, Suite 400 F
Boulder, CO 80302
marian@mariansalley.com
303.859.2611

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL AND PROTECTED HEALTH INFORMATION

Client Name:____
Parent/Legal Guardian (if applicable):______________________________
Address:____
City:____________________________ State:__________ Zip:________
Date of Birth:_______________________

I, ________________________________ give authorization and permission to Marian Salley LCSW LAC CGP ACS, to:

Release to   Obtain from   Exchange with

Name: ____
Address: ____
Phone: ___________________________

The following specific information only:

Verbal summary and discussion of treatment   Record of attendance only   Evaluations/Testing reports

Treatment summary   Complete Medical/Mental Health record   Treatment plan

Diagnosis/Psychiatric conditions   Drug/Alcohol abuse information   Psychotherapy Notes

Other: ____

The purpose of this release is:

Coordination of care	Treatment planning	Legal issues
Testing/assessment	Condition of court order/parole	At the request of the client

Other: ____

I understand the following: *(See CFR §164.508(c)(2)(i-iii))*

- **This authorization will expire in one (1) year from the date of signing, unless otherwise specified here: ____.**
- **The disclosure of health information is voluntary and I have the right to refuse to sign this authorization.**
- **I have the right to revoke this authorization in writing at any time, except to the extent information has already been released in reliance upon this authorization, by providing written notice to the provider's address on this form.**
- **The information released in response to this authorization may be re-disclosed to other parties by the recipient, in which case it would no longer be protected by federal privacy regulations.**
- **Unless the purpose of this Authorization is to determine payment of a claim or benefits, my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.**
- **If I have authorized the release of Drug or Alcohol conditions, Federal Law (42 CFR Part 2) protects the confidentiality of this information and prohibits unauthorized disclosure of these records.**

______________________	______________________	______________
Client Signature	Printed Name	Date

____

Relationship to Client (if applicable)

Any facsimile, photocopy, or other reproduction of this authorization is authorization to release the requested information.