CONSENT FOR RELEASE OF INFORMATION

I hereby authorize: Sabrina S. Santa Clara, PLLC and/or The Center for Embodied Spirituality
Sabrina Santa Clara, MA, LCPC, LPC, R-DMT, CIFST, RYT
PO Box 322, Lafayette, CO 80026 mobile: 303.955.8945
Email: Info@SabrinaSantaClara.com

☐ **To release information to** ☐ **To obtain information from**
(Check one box or both. By checking both, you are authorized an exchange of information between the agencies/individuals listed)

Agency/Individual _____ Individual: _____

Street: _____ Phone: _____

City/State/Zip: _____ Fax: _____

Email: _____

From the records of:
Client Name: _____ Date of Birth: _____

Purpose or need for disclosure is to assist in the preparation of: (check all that apply)
☐ Coordination of Services ☐ Continued Treatment ☐ Legal ☐ Other (specify) _____

Type of information to be disclosed: (check all that apply)

☐ Complete Medical Records	☐ Medical	☐ Alcohol & Other Drug
☐ Mental Health	☐ Psychiatry Notes	☐ Psychothera;y Notes
☐ Legal Records	☐ HIV/AIDS	☐ Other (specify) _____

Specific information to be disclosed: ***(check all that apply)***

☐ Progress Reports	☐ Intake Summary	☐ Assessments + Diagnoses
☐ Case Notes	☐ MVD Status Reports	☐ Treatment Goals & Plans
☐ Clinical Impressions	☐ Personal Knowledge	☐ Other (specify) _____

I understand that:

a) My records are protected under State and Federal regulations governing confidentiality
b) My signature on this form is strictly voluntary
c) I may revoke this authorization at any time in writing, and if I do it will not have any affect on any actions taken prior to receiving the revocation. Further details ay be found in the Notice of Privacy Practices.
d) If the requestor or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations.
e) If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.
f) I may inspect or obtain a copy of the health information that I am being asked to disclosed.

This consent (unless revoked earlier) expires 365 days from the signature date on: _____

_____ _____
Client Signature Date

_____ _____
Signature of Other Person Authorized to Consent (where applicable) Date

_____
Relationship to Client

_____ _____
Witness Signature Date