

Jamey Collins, LCSW _____

750 E. 9th Avenue, Suite 102
Denver, Colorado 80203

2043 Pearl Street (Arbor House)
Boulder, Colorado 80302

(303)641-6410

RELEASE OF INFORMATION FORM

I request and authorize my therapist Jamey Collins, LCSW to obtain from or give to

(Name) _____

(Address) _____

(Phone) _____

Information relevant to my treatment for the purpose of

(circle all that apply) Informed Treatment

Continuity of Care

Other _____

All information I hereby authorize to be obtained/given will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for the duration of my participation in therapy with Jamey Collins, LCSW. I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

(Date) _____ Client Name (Print) _____

Signature _____