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AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I (we), _____ [Insert Name of Client or Caregiver] authorize Lauri L. Korinek, Ph.D., PC, to release and obtain the following information:

Please initial each item to be released and/or obtained

- | | |
|---|---|
| <input type="checkbox"/> Assessment/Evaluation | <input type="checkbox"/> Current Treatment Update |
| <input type="checkbox"/> Client History | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Nursing/Medical Information | <input type="checkbox"/> Medication Management Information |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> School Behavior |
| <input type="checkbox"/> Toxicological Reports/Drug Screens | <input type="checkbox"/> Presence/Participation in Treatment |
| <input type="checkbox"/> Educational Information | <input type="checkbox"/> Scheduling / Cancelling Appointments |
| <input type="checkbox"/> Discharge/Transfer Summary | <input type="checkbox"/> Billing/Payment Information |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Other | |

Pertaining to me and/or my child, _____ Date of Birth _____

To and From: _____
Name of doctor, school, clinic, hospital, family member, etc. Phone Number

Street Address

City State ZIP code

Please list any part/s of the record you do not wish to have released _____
Otherwise, your records will be released as specified above.

I understand that the purpose of this disclosure of information is to improve assessment and/or treatment planning, share information relevant to assessment and/or treatment, and when appropriate, coordinate treatment services. I may revoke this authorization at any time by sending written notification to Lauri L. Korinek, Ph.D., PC, at 9364 Teddy Lane, Suite 204, Lone Tree, Colorado 80124. Otherwise, this authorization will automatically expire one year from the date below. I understand that if Lauri L. Korinek, Ph.D., PC, has released information based on this authorization before I revoke it, Lauri L. Korinek, Ph.D., PC, cannot get the information back. I also understand that Lauri L. Korinek, Ph.D., PC, has no control over how the above specified recipient may disclose released information. I understand that a copy of this authorization may be used in place of the original. I understand that authorizing the disclosure of this information is voluntary. I understand that I can inspect the information to be disclosed and I will be provided a copy of this authorization for my records.

Signature of Client/Caregiver _____ Date _____
Signature of Psychologist _____ Date _____