Rosamond Therapeutic Services, LLC
Ida Seiferd, MSW, LCSW
831 Royal Gorge Blvd Ste 226 Canon City, CO 81212
Phone: 303-801-8366

Client Authorization to Send, Receive, and/or Exchange (Release) Health Information

Client's Name: ____ DOB: ________________

I allow Rosamond Therapeutic Services to use, send, receive, and exchange the chosen information below with:

Name or title of person: ____

Agency or Organization: ____

Mailing Address: ____

City, State, Zip: _______________________________________ Phone: _____________________

Type of Information to be released or provided: ☐ All Health Information ☐ Only Mental Health/Psychiatry

☐ Only Substance Use ☐ Only Primary Care

DO NOT release or provide the information checked below:

☐ Substance use disorder medications ☐ Substance use disorder intake assessment ☐ Substance use disorder labs

☐ Substance use disorder progress notes ☐ Substance use disorder discharge summary ☐ HIV/AIDS

☐ Other: ____

Reason for release: ☐ Client request ☐ Other: ____

Other important information you need to know:

1. Even if I decide not to sign this form, I can still get treatment with Rosamond Therapeutic Services. In some cases, a court order, a referral from another agency, or other law may require Rosamond Therapeutic Services to share my information so I can get services. The law allows Rosamond Therapeutic Services to share some of my information, even if I do not sign a release.
2. Whenever Rosamond Therapeutic Services shares your information, we do everything we can to keep your information safe. Rosamond Therapeutic Services is not responsible if someone tries to steal your secure information, for example a computer hacker.
3. Copies of this form can be used instead of the original. We may accept electronic or faxed signature.

4. Rosamond Therapeutic Services cannot be sure that the person who receives your information will not share (re-disclose) it with someone else or protect it.
5. Rosamond Therapeutic Services has given or offered you a copy of this release.
6. I understand that my information may contain notes about communicable or sexually transmitted diseases (STDs), psychological or psychiatric conditions (mental health), and substance use disorder conditions.
7. This release will expire in one (1) year from the date I signed it unless I cancel (revoke) my permission in writing. I may cancel this release at any time. If I cancel my release, I understand Rosamond Therapeutic Services cannot take back any information that was shared before I cancelled this release.

Client's signature: ____ Date___________________

Guardian/representative: ____ Date___________________

Relationship to client: ____

Witness Signature and title: ______________________________________ Date___________________

CANCELLATION (REVOCATION): I revoke my authorization for this use and sharing my health information,

effective _____________ (date).

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Client Signature Date