Ruth Weinberg LPC
1726 Clarkson Street, Denver, Colorado 80218
ruth@ruthweinberg.com
720.432.1163

RELEASE/EXCHANGE OF INFORMATION

I, _____ hereby authorize and request
(Please Print Name)

the exchange of information between Ruth Weinberg, MS, LPC and

_____
(Name of Person)

_____
(Name of Agency) (Phone Number)

The information exchange may include all confidential medical, psychological or other appropriate information acquired in the course of evaluation and treatment.

The purpose of the information exchange is to assist in providing thorough and effective counseling services and will not be used for any other reason.

I understand that this consent will be in effect for one year following the date on this form. I understand that I may revoke this consent at any time by informing Ruth Weinberg MS, LPC in writing. In consideration of this consent, I hereby release the above parties from legal liability for the exchange of information.

Signature:_____ Date: _____

I, _____, whose Date of Birth is _____,
Name of Client

authorize Ruth Weinberg, MS, LPC to disclose to and/or obtain from:
_____
Name of Person or Title of Person or Organization

the following information:

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed)
_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information
_____ Toxicological Reports/Drug Screens
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Other_____
_____Other_____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.
If other purpose, please specify:
_____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to
Ruth Weinberg, MS, LPC 1731 E. 16th Ave. Denver, CO 80218. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.
Expiration
Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated: _____

Conditions

I further understand that Ruth Weinberg MS, LPC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____
_____
_____
[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the
services being provided].

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to NATIONAL ASSOCIATION OF SOCIAL WORKERS DOCUMENT C2

be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or
electronically.
Redisclosure
Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of
substance abuse treatment information unless further disclosure is expressly permitted by the written authorization
of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be
re-disclosed by the recipient of the information in the following
circumstances:_____
_____
I will be given a copy
of this authorization for my records.

_____
___
Signature of Patient/Client Date

_____
___
Signature of Parent, Guardian or Personal Representative Date
If you are signing as a personal representative of an individual, please describe your authority to act for this
individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____
___
Witness Signature Dat