2nd Star Counseling, LLC

www.2ndstarcounseling.com

Kathryn Raley
MA, NCC, LPCC
BS Secondary Education, Language Arts
Certificate Counseling Youth and Adolescents
Certificate Transpersonal Counseling
720-515-8796

Sondermind Counseling
(formally YOUnique)
2855 N Speer Blvd
Denver, CO
Lafayette, CO
kathryn@2ndstarcounseling.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: Date of birth

Address City, State, Zip:

Please note: this form is attached to a list of resources that may be contacted at the discretion of the therapist, Kathryn Raley, with the permission of the client (guardian)_____.

- ☐ I authorize Kathryn Raley to release information to the following.
- ☐ I authorize Kathryn Raley to obtain information from the following.

TITLE	NAME/ORGANIATION	PHONE

Purpose of this request (Check all that apply)

- ☐ Coordination of Services
- ☐ Medical Records
- ☐ Other (please describe)_____

Type of records authorized

- ☐ Psychiatric/Psychological evaluation and /or treatment
- ☐ Drug/alcohol evaluation and/or treatment

Specific information authorized (select one or more as appropriate):

❑ Assessments ❑ Progress Notes ❑ Diagnosis ❑ Discharge summary

❑ Treatment plans ❑ treatment summary ❑ Other (please describe.) _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to th person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire:

❑ When I am no longer receiving services from Kathryn Raley, 2nd Star Counseling, LLC.
❑ One year from this date. ❑ Other:_____

I understand that:

- I do not have to sign this authorization and that may refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time bu submitting a written request to Kathryn Raley, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical professional, covered by privacy regulations, the information stated above could be re-disclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.

Signature of Parent, Guardian, or Adult: _____ Date: _____

Relationship to client (if the requester is no the client): ❑ Parent ❑ legal guardian ❑ Other: _____

❑ A copy of this authorization has been provided to the parent, guardian or adult: _____