MARGIT COX HENDERSON, PH.D.
Licensed Clinical Psychologist (CO #2236)
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Phone: (303) 257-2427

RELEASE/REQUEST OF INFORMATION or AUTHORIZATION

I _____ (DOB: ___/___/___) hereby authorize the exchange of information between Margit Cox Henderson, Ph.D. and:

Name: _____
Address: _____
_____
Phone: _____

The type of information to be disclosed is regarding:

- ☐ Psychological assessment
- ☐ Psychological treatment
- ☐ Other: _____
- ☐ Extent of participation in treatment
- ☐ Medical issues

The purpose of this information exchange is:

- ☐ Coordination of care
- ☐ Continuity of care
- ☐ Assessment
- ☐ Release of Psychotherapy Notes
- ☐ Treatment
- ☐ Payment
- ☐ Operations
- ☐ Other: _____

If "Release of psychotherapy notes" or "Other" is checked, regardless of whether additional purposes are also checked, this form is a **HIPAA compliant Authorization**. As such, the Practitioner may not condition treatment, payment, enrollment in a health plan, or eligibility for health plan benefits on my signing this Authorization. Also, if this is an Authorization, Dr. Henderson must provide me with a copy. I understand that there exists a potential for the information disclosed to be subject to re-disclosure by the recipient and that it may no longer be protected by the HIPAA Privacy Regulation.

This consent is in effect until ____/____/____ or one year after the end of treatment.

I hearby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy or faxed copy of this release shall be as valid as the original.

_____ _____
Client Signature Date

_____ _____
Therapist or Witness Signature Date

Notice to Recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosures of this information except with specific written consent from the person to whom it pertains or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.

This authorization has been revoked by the client (letter in file).
_____ Recorded by: _____
Date