



**Request for Release of Confidential Medical Records**

I, \_\_\_\_\_ (client), DOB: \_\_\_\_\_ request that my medical records are released/exchanged/received from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

and disclosed/exchanged to :

**River View Counseling, PLLC  
P.O. Box 678  
Kremmling, CO 80459  
Phone: 970-531-1996**

For the purpose of: \_\_\_\_\_

Information to be released/exchanged/received:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> entire medical record         | <input type="checkbox"/> diagnoses     | <input type="checkbox"/> school reports: grades, behavior, IEP |
| <input type="checkbox"/> laboratory results            | <input type="checkbox"/> participation | <input type="checkbox"/> treatment recommendations             |
| <input type="checkbox"/> psychological testing/reports | <input type="checkbox"/> attendance    |  |
| <input type="checkbox"/> discharge summary             | <input type="checkbox"/> Other: _____  |  |
| <input type="checkbox"/> treatment summary             |  |  |

This Request for Release of Information was initiated on \_\_\_\_\_ and expires on \_\_\_\_\_.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon, and in any event, this consent expires automatically one year from the date signed.

I also understand that this information is or may be protected by federal regulations and hereby release River View Counseling, PLLC, Mary Entrican, and the individual or institution named above from any liability associated with the release of this information.

Client Name (printed): \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_

Parent Name (printed): \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Witness Name (printed): Mary Entrican, MS, LMFT

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: Licensed Marriage and Family Therapist and President/Owner