



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 Fax: 970-725-3239

For the purpose of: _____

Information to be released/exchanged/received:

- | | | |
|--|--|--|
| <input type="checkbox"/> Entire medical record | <input type="checkbox"/> Participation | <input type="checkbox"/> Treatment recommendations |
| <input type="checkbox"/> Laboratory results | <input type="checkbox"/> Attendance | <input type="checkbox"/> Substance use and treatment |
| <input type="checkbox"/> Psychological testing/reports | <input type="checkbox"/> School reports: grades, behavior, IEP | |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Treatment summary | | |
| <input type="checkbox"/> Diagnoses | | |

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 understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 and 164. I also understand that this confidential medical record information is protected by Colorado Revised Statutes 24-72-202 (4) and 27-10-120. This information cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in one year.

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**