AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

NAME_____BIRTHDATE_____

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I hereby authorize DANA L. COGAN, M.D., at 600 South Cherry Street, Suite 315, Denver, CO 80246 to:

( ) RELEASE confidential information
( ) RECEIVE confidential information

TO/FROM:_____

ADDRESS:_____

_____

TELEPHONE NUMBER: _____ FAX NUMBER:_____

INFORMATION TO BE RECEIVED/RELEASED:

( ) Information pertaining to psychotherapy
( ) Medical records ( ) Evaluation report(s)
( ) Hospital records ( ) Police report(s)
( ) Probation report(s) ( ) Marital counseling
( ) Alcohol/drug abuse tx ( ) Dept. of Human Services

( ) Other _____

PURPOSE OF RELEASE:

( ) To exchange verbal information and records with another treatment provider
( ) To receive information to be used in a parental responsibility evaluation
( ) To receive information to be used during parenting coordination
( ) To receive information to be used in a mediation and/or arbitration
( ) To receive information to be used in an independent psychiatric evaluation

( ) Other _____

RELEASE FROM LIABILITY:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, and drug and/or alcohol abuse.

EXCLUDE the following information from the records released (please initial):

_____ Drug/alcohol abuse/treatment and diagnosis

_____ HIV/AIDS and/or STD diagnosis/treatment/testing

I understand that I do not have to sign this authorization to obtain health care benefits (treatment, payment or enrollment).

I understand that I am free to revoke this release authorization at any time by notifying Dr. Cogan in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

I understand that Dr. Cogan will act on this release once it is signed. I understand that any release of information prior to my revoking the release shall not constitute a breach of my right to confidentiality.

I understand that Dr. Cogan must provide information to the police and/or the Department of Human Services if he suspects child abuse or believes that a person is dangerous to himself and/or others. I understand that Dr. Cogan may be required by law to release information even after I have revoked this release authorization. In such an instance, I agree to hold Dr. Cogan harmless regarding the release of my protected health information.

AUTOMATIC EXPIRATION:

( ) One (1) year from date signed ( ) Other: _____

_____ _____

SIGNATURE DATE