Alisha L. Brosse, Ph.D., LLC
3020 Carbon Place, Suite 200
Boulder, Colorado 80301
Phone: 720/252-0611
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AUTHORIZATION FOR RELEASE/REQUEST/EXCHANGE OF INFORMATION

I request and authorize Alisha L. Brosse, Ph.D., to:

Release ___ Request ___ Exchange XX information (in written or verbal form) regarding

_____

Client's name Date of Birth

to/from/with _____

Name of Person/Agency/Organization/Physician

_____

Address

_____ _____

Phone Fax

I understand that the information to be requested/released/exchanged includes information regarding:

XX Psychological or psychiatric conditions, if any
XX alcohol/substance use, if any
XX Health related conditions, if any
___ Other: _____

I understand that the information requested/released/exchanged will be used to:

___ Aid in evaluation and treatment.
___ Other: _____

I certify that this request and authorization has been made voluntarily. I understand that I may revoke this authorization at any time, and that it will automatically expire 3 months after my treatment ends. Redisclosure of my records by those receiving the authorized information is prohibited. I hereby release both of the above parties from any liability which may result from furnishing the information released, requested, or exchanged.

Signature of client_____ Date_____

Signature of legal guardian_____ Date_____

Signature of witness_____ Date_____