Alisha L. Brosse, Ph.D., LLC
3020 Carbon Place, Suite 200
Boulder, Colorado 80301
Phone: 720/252-0611
Fax: 303/484-1636

**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                    (Relation)

____________________________________________________
Address

____________________          ____________________
Phone                                        Fax

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

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

This release is limited to:

___ Billing-related information (e.g., diagnosis, sessions dates, missed sessions)
___ Conjoint sessions (i.e., client and person(s) meet together with therapist)
___ Acute crisis management

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____________