Peace of Mind Counseling, LLC

Jael A. Esquibel, MA, LPC, NCC
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RELEASE OF INFORMATION

I, (PRINT CLIENT NAME) _____ Date of Birth _____, hereby authorize Jael A. Esquibel, MA, LPC, NCC to disclose and/or receive confidential information regarding me and/or my child's therapy treatment. This includes: medical records, treatment notes, progress notes, evaluations, assessment results, and reports or records of other treatment providers. I authorize Jael A. Esquibel, MA, LPC, NCC to disclose confidential information concerning me and/or my child verbally and in writing. I authorize Jael A. Esquibel, MA, LPC, NCC to use professional judgment in deciding what specific information will be released and communicated. I authorize the exchange of information with the following agencies and/or individuals:

Information to be released to or from:

Name of agency or person: Address/Telephone:

_____

_____

_____

_____

DISCLOSURE REGARDING CONFIDENTIALITY OF TREATMENT INFORMATION

I understand that any treatment records concerning me and/or my child's medical or mental health treatment are protected under Colorado law and federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that if I request records to be released to any person or health care provider, I am responsible for payment or expenses for the copying of the records, and agree to pay for them; or that I will be responsible for payment for any summary of confidential health care information, which is disclosed instead of specific records, at the discretion of Jael A. Esquibel, MA, LPC, NCC.

I understand that authorization disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand that I am entitled to a copy of the signed authorization form. I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing. I understand my revocation will not be effective to the extent that action has been taken in reliance on it. If I have authorized disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy of this authorization will be valid as the original.

_____ _____
Client's Signature Date

_____ _____
Legal Guardian's Name (Please Print) Date

_____ _____
Legal Guardian's Signature Date

This authorization expires upon and cannot be used past the following date: (Not to exceed two (2) years): _____

I hereby revoke this consent to Release/Authorization for Information:

Client/Guardian Signature _____ Date _____ Witness Signature _____ Date _____