Erin M. Thomas, MA, LPC

Erin M Thomas Therapy, LLC. **1200 S. College Ave, Suite208**
(970) 672-5535 (office) **Fort Collins, CO 80524**

RELEASE OF INFORMATION

I hereby authorize Erin M. Thomas, MA, LPC 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, and reports or records of other treatment providers. I authorize Erin M. Thomas, MA, LPC to disclose confidential information concerning me and/or my child verbally and in writing. I authorize Erin M. Thomas, MA, LPC 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:

_____ Larimer County Department of Human Services
_____ Poudre School District (specify school) _____
_____ Thompson School District (specify school) _____
_____ Fort Collins Police Department
_____ Loveland Police Department
_____ Larimer County Sheriff's Department
_____ 8th Judicial District Attorney
_____ Larimer County Child Advocacy Center
_____ Medical Professional (specify name) _____
_____ Partners Mentoring Youth
_____ Others (specify names) _____

_____

_____

Disclosure Regarding Confidentiality of Treatment Information

I understand that any treatment records concerning me and/or my child's medical treatment or mental health evaluations are confidential under Colorado law, and that a statutory privilege prohibits confidential treatment information from being disclosed without my consent. I understand that if I request records to be released to any person or health care provider, I am responsible for payment for 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 Erin M. Thomas, MA, LPC.

I understand that I have no obligation to sign this authorization for the disclosure of confidential information about myself and/or my child. **I understand that I may revoke this consent in writing for disclosure of information at any time**.

_____ _____
Child's Name Date of Birth

_____ _____
Client's Name or Legal Guardian's Name Date of Birth

_____ _____
Signature of Client or Legal Guardian Today's Date