Kaleidoscope
THERAPY SERVICES, LLC

Kelly Garcia-Brauch, LPC
673 Grant St.
Denver, CO 80203
303.829.7904
Kelly.garciabrauch@gmail.com

Authorization for Release of Information

Client name: _____

DOB: _____ **Date:** _____

Family Name: _____

I, the above named individual/guardian of the minor child listed above, hereby authorize Kaleidoscope Therapy Services LLC to:

☐Release confidential information ☐Receive confidential information

To/From: _____

Information requested:

Admission/Assessment/ Evaluation	Treatment plans
Drug/Alcohol Evaluation	Discharge Summary
Medical Records	Child Welfare Case Notes
Court Reports	**Other:**

Reason:

_____

_____

(Copies may be used in lieu of original)

Automatic Expiration: 6months from date signed

_____ _____

Client signature Date Therapist signature Date

Release from liability: I understand that my records are protected under the Federal regulations governing Confidentiality 43 CFR Part 2, and cannot be disclosed without written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action had been taken in reliance on it.

NOTICE TO RECIPENT (S) OF INFORMATION: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS, WHICH ARE PROTECTED, BY FEDERAL LAW. REGUALTIONS PROHIBT YOUR FUTHER DISCLOSURE WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.