ANIMAL ASSISTED THERAPY PROGRAMS OF COLORADO

AUTHORIZATION TO RELEASE & EXCHANGE INFORMATION

Agency: _____ **ATTN:** _____
_____
_____
_____ _____

Client Name: _____ **DOB:** _____ **Record#:** _____

I, _____, hereby authorize _____
(Client/Guardian Name) (Agency or Person Releasing/Exchanging Information to AATPC)

to exchange information with AATPC.

Purpose(s) or need for which information is to be used:

☐ Continuity of Service Provision ☐ Other
_____

Information to be Released:

☐ Presence in Treatment	☐ Educational Information	☐ Psychiatric History
☐ Verbal and Written Progress	☐ Psychological Evaluation	☐ Medication History
☐ Treatment Plan/Recommendation	☐ Probation/Parole Conditions	☐ Psychosocial History
☐ Copy of Aftercare Plan	☐ Financial Information	☐ Criminal Justice History
☐ Physician's Orders	☐ Discharge Summary	☐ Other_____

I understand that information to be released may include information regarding the following:

☐ Chemical Abuse and/or Dependency	☐ Psychiatric Conditions	☐ HIV/AIDS Testing or Status
☐ Criminal Records	☐ Judiciary Recommendations	☐ Other _____

IMPORTANT NOTE:
If the information to be released pertains to the diagnosis and treatment of alcoholism and/or drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42 C.R.S. Part 2.

Authorization:
I certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has been taken to comply with it. I understand that this consent will expire upon termination of therapy or upon _____. I hereby release any service provider or individual from any liability, which may result from furnishing the information requested as authorized in this release. Redisclosure of my medical records **may not** be accomplished without further written consent.

A COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

Client Signature: _____ Date:_____

Therapist/Witness: _____ Date: _____