www.pursuitsnetwork.com | 303.886.0272

Authorization For Release of Information

I, __________________________________, hereby authorize

____________________________ with Pursuits Network

to exchange information with

The type of information to be disclosed:
Assessment and Progress Notes
The purpose of such disclosure:
Consultation_____
Coordination of Care_____

The designated information about me ( ) may
be transmitted by fax at
The above designated person ( ) may discuss by telephone the content of the information released.

This consent is in effect until____________________________.

I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place.

I hereby release all parties stated herewith from any liability resulting from the release of this information.

I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization.

The information provided by a client during sessions is legally confidential in the except as provided in section 12.43.218 CRS and except for certain legal exceptions.

In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Date ___________________________
Signature of Client ______________________________

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.