Gift of Psychotherapy

Blake Roberts MA, LPC

Licensed Professional Counselor

2855 N. Speer Blvd., Suite C; Denver, CO 80211

720-232-0429

Consent for the Release of Confidential Information

I, _____, hereby authorize release of patient/client records and any other details of my care between:

_____

AND

For the purpose of assisting in the evaluation of my treatment and/or development of my treatment plan.

The consent expires upon the termination of my treatment or on the date specified: _____

I have had this explained to me and fully understand this request/authorization to release records and information; including the nature of my records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already transpired.

Signature of Client: _____ Date _____

Signature of Parent or Legal Guardian: _____ Date _____

Signature of Therapist: _____ Date _____