Dee Dee Woodman M.Ed., LPC
3020 Fenton St
Wheat Ridge, CO 80214
Office 303-467-1544
Fax 303-569-6026

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____

Date of Birth: _____ Admission Date: _____

Information to be released to (including full name of facility and/or person):
_____
_____
I, _____, hereby authorize Dee Dee Woodman M.Ed,

LPC to release/obtain the following information including any psychiatric (including

medications), alcohol/drug dependency information to the aforementioned party and/or

facility but limited to the following:

Client/Family Assessment _____ Discharge Summary_____

Aftercare Plan _____ Therapist Consult _____

Laboratory Results _____ Client Records _____

Verbal/Written Progress _____ Other _____

This authorization may be revoked by you at any time except to the extent that the action has already been taken to comply with it. NOTICE TO WHOMEVER THIS DISCLOSURE IS MADE: this information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit you from making further disclosure of this information without the specific consent of the person to whom it pertains, or as otherwise excepted/permitted by such regulations.
I hereby certify that I have read, or have had read to me, this notice regarding the credentials of my therapist and my rights as a client, as provided under the Colorado Mental Heath Act.

_____ _____
Client Signature Date