Office: 720-898-4800   Fax: 720-898-5169
www.raphacc.com

Authorization For Release of Information

I, ________________________________, hereby authorize Fara Murata, LCSW and ________________________
Parent   Organization/Name
at ________________________ to exchange information regarding _______________________________________.
Telephone   Child's Name

The type of information to be disclosed:

Evaluations _____ | Medical/Hospital Records_____
Diagnosis _____ | Psychological/Medical Test Results_____
Treatment Plan_____ | Mental Health Record Summary_____
Course of Treatment_____ | Psychotherapy Notes _____
Other ____________________

The purpose of such disclosure:

Ongoing Treatment___x__ | Medical Care_____ | Consultation_____
Evaluation_____ | Transfer_____ | Legal issues_____
Coordination of Care__x___ | Health Benefit Utilization_____ | Other __payment__

Exceptions:____

The designated information about me (x) may ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Fara Murata, LCSW and the above designated person (x) may ( ) may not discuss by telephone the content of the information released.

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.

AUTHORIZATION: I hereby acknowledge that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. This authorization may be used or reused to obtain subsequently prepared records pertaining to treatment of any type after the date of this release as long as this authorization remains valid. This authorization shall be valid for one year from the date of my signature. I understand that when this information is released it may no longer be protected by the HIPAA Federal Privacy Regulation. I also hereby acknowledge that treatment, payment, or eligibility for benefits were not conditioned on my signing this authorization.

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 or Personal Represent**