Vail Valley
Therapy Solutions
Alisha L. Brosse, PhD · Licensed Psychologist

AUTHORIZATION FOR RELEASE/REQUEST/EXCHANGE OF INFORMATION

I request and authorize Alisha L. Brosse, Ph.D. and Vail Valley Therapy Solutions, to:

Release ___ Request ___ Exchange XX information (in written or verbal form) regarding

_____
Client's name Date of Birth

to/from/with _____
Name of Person/Agency/Organization/Physician

_____
Address

_____ _____
Phone Fax

I understand that the information to be requested/released/exchanged includes information regarding:

XX Psychological or psychiatric conditions, if any
XX alcohol/substance use, if any
XX Health related conditions, if any
___ Other: _____

I understand that the information requested/released/exchanged will be used to:

___ Aid in evaluation and treatment.
___ Other: _____

I certify that this request and authorization has been made voluntarily. I understand that I may revoke this authorization at any time, and that it will automatically expire 3 months after my treatment ends. *Redisclosure of my records by those receiving the authorized information is prohibited*. I hereby release both of the above parties from any liability which may result from furnishing the information released, requested, or exchanged.

Signature of client_____ Date_____

Signature of legal guardian_____ Date_____

Signature of witness_____ Date_____