



Therapy Solutions
Alisha L. Brosse, PhD · Licensed Psychologist

AUTHORIZATION FOR RELEASE/REQUEST/EXCHANGE OF INFORMATION

I request and authorize Alisha Brosse, PhD and/or other agents of Vail Valley Therapy Solutions to RELEASE, REQUEST, or XX EXCHANGE 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 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 exchanged will be used to:
XX Provide continuity/coordination of care
XX 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. Redislosure 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 _____