



Dr. Beth Firestein
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AUTHORIZATION TO RELEASE INFORMATION

I, _____, (hereinafter "Patient") hereby authorize **Beth A. Firestein, Ph.D.**, (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to:

Name _____ Phone: _____
Address: _____ Fax: _____
email: _____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. **And, I also understand that such revocation must be in writing and received by Provider at 504 W. Eisenhower Blvd., #202, Loveland, CO 80537, to be effective.**

The disclosure of information and records authorized by Patient is required for the following purpose: _____

The specific uses and limitations of the types of medical information to be discussed are as follows: _____

Such disclosure shall be limited to the following specific types of information:

Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form. Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy Rule.

This authorization shall remain valid until: _____

Patient's Signature: _____ Date: _____

Confidential Material

If you receive this information in error, please call (970) 635-9116 to arrange for return of material. **This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Fed Regulation (42 CFR, Part 2) prohibits you from making further disclosure without the specific written permission of patient.**