AUTHORIZATION TO RELEASE/RETRIEVE MENTAL HEALTH INFORMATION

I hereby consent to Michelle F. Cox, LCSW to ***Release*** information to the following parties. This includes written and verbal transfer of history, mental health, and treatment information, for the purposes of consultation and coordination with relevant professionals.

These Individuals Are As Follows:

Name Address Phone Number

_____

_____

_____

I hereby consent to Michelle F. Cox, LCSW to ***Retrieve*** information from the following parties. This includes written and verbal transfer of history, mental health, and treatment information, for the purposes of consultation and coordination with relevant professionals.

These Individuals Are As Follows:

Name Address Phone Number

_____

_____

_____

AUTHORIZATION: I certify that this release has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

This authorization should be valid for:

_____ 12 Months from the date of my signature;

_____ Months from the date of my signature; Or

_____ Until thirty (30) days after the termination of treatment with Michelle F. Cox, LCSW.

A facsimile or copy of this release shall be treated as an original.

_____ _____
Client's Name (please print) **Date**

_____ _____
Client/Parent/Guardian Signature **Relationship to Client**

_____ _____
Michelle F. Cox, LCSW **Date**

Michelle F. Cox, LCSW
Counseling & Psychotherapy 303-563-7028 mfcox.lcsw@gmail.com