New Pathways Psychotherapy, Pllc.
13701 W. Jewell Ave., Suite 200-19
Lakewood, CO 80228
(720) 640-7876

AUTHORIZATION TO RELEASE / EXCHANGE INFORMATION

Client Name: _____

Date of Birth: _____

I, _____, hereby authorize **New Pathways Psychotherapy, PLLC** (hereinafter "Provider") to disclose and/or exchange mental-health treatment information and records obtained in the course of psychotherapy treatment, including but not limited to the therapist's diagnosis, for the client named above **to/from**:

Recipient Information	
Name/Organization	_____
Phone	_____
Address	_____
City/State/ZIP	_____
Fax	_____

Purpose of Disclosure

☐ At the request of the individual
☐ Other: _____

Types of Use / Disclosure (check all that apply)

☐ Treatment Coordination
☐ Treatment Planning
☐ Diagnostic Refinement
☐ Other: _____

Specific Information to be Released (check all that apply)

☐ Psychiatric Diagnosis(es)
☐ Dates of Treatment
☐ Treatment Summary
☐ Initial Treatment Plan
☐ Full Treatment Record
☐ Other: _____

Expiration

This authorization shall remain valid until: _____ (not to exceed one year from the date signed).

Important Information

- **Right to Copy & Revoke:** I understand I have a right to receive a copy of this authorization and that I may revoke it in writing at any time unless the Provider has already acted in reliance on it.
- **No Condition for Treatment:** My treatment will not be conditioned on signing this authorization.
- **Redisclosure:** Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state law may offer additional protections.

Signature	Date
Client _____	_____
Legal Guardian (if applicable) _____	_____
Relationship to Client _____	