CENTRAL FOCUS
PSYCHOLOGICAL GROUP

1259 Lake Plaza Dr., Suite 255
Colorado Springs, CO 80906

P:(719) 598-3585/ F:(720) 358-2674
www.centralfocusgroup.com

# Release of Information

**Identifying Information:**

| | |
|---|---|
| Name | Date of Birth |
| Address (include city, state, zip) | Phone Number |

**Release From and To:**

**I authorize information about the above referenced individual to be exchanged between Central Focus Psychological Group and the following System of Care User Group agencies or programs as listed below. Please notate if you wish for Central Focus Psychological Group to receive and/or exchange information between parties. Check one or both as applicable.**

1. ☐ Obtain information from: Name:_____
   ☐ Send information to: Fax:_____
   Phone:_____

2. ☐ Obtain information from: Name:_____
   ☐ Send information to: Fax:_____
   Phone:_____

3. ☐ Obtain information from: Name:_____
   ☐ Send information to: Fax:_____
   Phone:_____

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I understand the information disclosed may be in written, verbal, or electronic form, and may include date(s) of contact, location, reasons for contact, symptoms presented, treatment progress, outcome information, prescriptions, written referrals, educational records, medical records, tests performed, and/or diagnoses. I understand that disclosure may include psychological/psychiatric, medical, shelter and case management, and/or alcoholism, drug and/or alcohol abuse information.

I understand the purpose of this information disclosure is to allow the participating entities (identified above) to access and use the information to establish and maintain continuity of care, better assess the effectiveness of the program, and/or to improve their services based on service utilization studies.

I understand that I may refuse to sign this authorization, and no one is condition treatment, payment, enrollment, or eligibility for benefits on signing this authorization.

I understand that there is potential for information disclosed, because of this authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPPA Privacy Regulations. When applicable, an assessment of the minimum necessary amount of information required has been applied to this authorization.

I understand that I may revoke this authorization at any time by giving written notice to the authorized System of Care User Group agencies or programs, except to the extent that action has already been taken to comply with it. Without such revocation this authorization will expire on (or if left blank) one year from my signature date.

**Signature** **Date**