AUTHORIZATION FOR RELEASE OF INFORMATION

I, hereby freely, knowingly, and voluntarily authorize

to release all information, in oral and/or written form, from your records to InnerWorkings Professional Services for the purpose of my evaluation and/or treatment.

I further authorize InnerWorkings Professional Services to release the below described information to

The specific type of information that may be disclosed is

for the purpose of evaluation and treatment planning.

This consent is valid no longer than the period of time necessary to carry out the stated purpose of the request for information. I am aware that the consent may be revoked at any time by myself unless I am participating in treatment as a formal condition of diversion, probation, parole, release from confinement, or a court ordered Social Services/Human Services treatment plan, in which case consent cannot be revoked until there is a formal termination or revocation.

Client Signature or Authorized Person under 2:15 or 2:16

Date

Witness Parent or Legal Guardian

NOTICE TO RECIPIENT: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Further, regulations (42CFT Part 2) prohibit you from making further disclosure of it without the specific written consent of persons to whom it

Thomas J Pals, LPC, NCC Board Certified Counselor
Cell: 970-302-3379 thomasjpals@innerworkings.org
4800 Wadsworth Blvd, Suite 104 Wheat Ridge, CO 80033

pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is ***NOT*** sufficient for this purpose.