Principle Skills Relationship Center
7710 N. Union Blvd., Suite 202, Colorado Springs, CO 80920
719-494-7412
www.principleskills.com

Intake Forms

Authorization for Release of Confidential Information

I (Client Name) _____ (D.O.B) _____

(Client Name) _____ (D.O.B) _____

authorize **Principle Skills Relationship Center,** and the persons or entities listed below, or their representatives, to mutually release and disclose my health information:

Name/Agency:

Address/Phone #:

I have received and reviewed the *Notice of Privacy Practices*.
I understand that by signing this *General Authorization* I am authorizing **Principle Skills Relationship Center** to disclose my health information to the persons and entities listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to **Principle Skills Relationship Center**. My health information includes:

Treatment summary - session dates and progress
records and reports
test results
opinions and recommendations
assessments
any other information relating to medical, emotional, educational or psychological condition

I understand that I may revoke this authorization at any time by signing a written notice of revocation to **Principle Skills Relationship Center**. I understand that my revocation of this *General Authorization* will not affect a disclosure that has already made under this authorization.

I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by **Principle Skills Relationship Center's** confidentiality rules.
This authorization is only valid until _____(fill in date), or until 3 months after my file is closed with Principle Skills Relationship Center.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____