ALICEN L. HALQUIST, MA, LPC, SEP

Authorization for Release of Medical Information From and To the Alicen Halquist, MA, LPC, SEP

Patient Name _____ Date of Birth _____

Address _____

City/State/Zip _____ Phone_____

Parent/Guardian/Requestor Completing This Form

_____

RELEASE FROM:

I authorize the following institution to release Medical Record information to Alicen Halquist, LPC

Name _____

Address/City/State/Zip _____

Phone _____ Fax _____

Psychologist/Therapist/Other:

Name _____

Address/City/State/Zip _____

Phone _____ Fax _____

INFORMATION TO RELEASE

State/Federal Laws require specific authorization to release the following types of information. Please initial beside the types of information to be released:

_____ Complete Medical/Mental Health Record

_____ Mental Health Psychotherapy Notes Drug/Alcohol Abuse HIV/AIDS Related

_____ Other:_____

RELEASE TO:

Alicen Halquist
2019 19th Street,
Boulder, CO 80302
303-517-5430

_____ _____

Signature (Client/Legal Representative) Date