Linda K. Lute, LAC, MAC
970-946-6465

Authorization to Request and/or Release Information

I, _____ hereby authorize Linda Lute, LAC, MAC to disclose and/or obtain health information as described in this authorization.

[1] Specific person/organization to whom Linda Lute, LAC, MAC, is authorized to disclose information:

_____

_____

[2] Specific description of the information to be disclosed:

_____

_____

[3] Purpose for disclosure of Personal Health Information:

_____

_____

Right to Revoke*:* I understand that I have a right to revoke this authorization, in writing, at any time, by signing the revocation below or providing written request to Linda lute, LAC, MAC by e-mail. I further understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

Conditions: I understand that I am under no obligation to sign this form. I acknowledge that I am voluntarily signing this form to release my personal health information to the party I have designated.

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner deemed to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure**:** I understand that after this information is disclosed, federal law might not protect it, and the recipient might redisclose it.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

Photocopy or Facsimile: A photocopy or facsimile of this signed authorization form shall be considered as valid as an original signed copy.

Unless revoked sooner, this consent expires on the following date: _____

_____
Signature of Client Date

_____
Signature of Therapist Date