MICHELLE GOURLEY
& ASSOCIATES
Member of ChoicePoint Clinical Group

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AUTHORIZATION TO RELEASE INFORMATION (Updated 2026)

Client's Name:_____ Date of Birth:_____
Social Security #:_____

I request and authorize M. Michelle Gourley, MFT, LCSW, JD to release/receive healthcare information of the patient named above ☐ TO/ ☐ FROM (*check one or both*):

Name (person, professional, agency): _____

Address:_____ City: _____ State:_____ Zip Code: _____

Phone: _____ Email: _____

The Type of Information to Be Disclosed:

Evaluations _____ Medical/Hospital Records_____ Diagnosis _____ Treatment Plan_____ Mental Health Record Summary_____ Course of Treatment_____ Psychotherapy Notes _____ Other_____

The Purpose of Such Disclosure:

Evaluation_____ Consultation_____ Ongoing Treatment_____ Medical Care_____ Transfer_____
Legal Issues_____ Coordination of Care_____ Health Benefit Utilization_____ Other _____
Exceptions:_____

The designated information about me ☐ may ☐ may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. M. Michelle Gourley, MFT, LCSW, JD and the above designated person ☐ may ☐ may not discuss by telephone the content of the information released.

This consent is in effect until_____(date). I understand that I may revoke this authorization, *in writing*, at any time unless action based on it has already take place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except

as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.
I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____ ____/____/____
Signature of Client or Personal Representative Date

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.

This authorization to disclose private health information is for the release of mental health assessment, psychotherapy notes or purposes other than my treatment, payment or the related operations of the practice, and I understand that my authorization, or refusal, will not affect my ability to get treatment or payment. However, the Practitioner can condition those things (1) if my treatment is related to research, or (2) if my treatment is being provided to me solely for the purpose of creating protected health information for disclosure to a third party.

By my signature below, I acknowledge a receipt of this disclosure.

_____ ____/____/____
Signature of Client or Personal Representative Date