Jeffrey Nelson, LCSW, PLLC
1777 S. Bellaire St. Ste: 220
Denver, Colorado 80222

Release of Information

This document, signed by the client, allows information to be shared by the client's therapist to a third party. Information may also be shared from the third party to the client's therapist.

I, (print name):_____; Date of birth: _____, agree to allow Jeffrey Nelson, LCSW, to release the following information regarding my (my child's) treatment, including information about diagnosis, medical information, history, previous treatment, current treatment & progress, for purposes of further evaluation and/or continuity of care. Information may also be obtained from the third party by the therapist. Use this space for specific instructions regarding information to be shared if necessary:

_____
_____
_____
_____.

With whom information may be exchanged:

Primary Care Physician: YES_____ NO_____ if yes, write name and contact number:

_____

OR

(Please note that two names cannot be listed on one Release of Information form; please ask if you need another form):

Psychiatrist: YES____NO____ N/A____ if yes, write name and contact number: _____

_____

_____ _____
Signature of Client (parent if under 18) Date

_____ _____
Signature of Client Date

_____ _____
Jeffrey Nelson, LCSW Date