



Office: 720-898-4800 Fax: 720-898-5169  
 www.raphacc.com

**Authorization For Release of Information**

I, \_\_\_\_\_, hereby authorize Fara Murata, LCSW and \_\_\_\_\_  
 Client Organization/Name  
 \_\_\_\_\_ at \_\_\_\_\_ to exchange information.  
 Telephone

The type of information to be disclosed:

- |                           |  |
|---------------------------|--|
| Evaluations _____         | Medical/Hospital Records _____           |
| Diagnosis _____           | Psychological/Medical Test Results _____ |
| Treatment Plan _____      | Mental Health Record Summary _____       |
| Course of Treatment _____ | Psychotherapy Notes _____                |
| Other _____               |  |

The purpose of such disclosure:

- |  |                                  |   |
|--|----------------------------------|---|
| Ongoing Treatment <input checked="" type="checkbox"/>    | Medical Care _____               | Consultation _____                                |
| Evaluation _____   | Transfer _____                   | Legal issues _____                                |
| Coordination of Care <input checked="" type="checkbox"/> | Health Benefit Utilization _____ | Other <input checked="" type="checkbox"/> payment |

Exceptions: \_\_\_\_\_

The designated information about me ( x ) may ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Fara Murata, LCSW and the above designated person ( x ) may ( ) may not discuss by telephone the content of the information released.

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.

**AUTHORIZATION:** I hereby acknowledge that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. This authorization may be used or reused to obtain subsequently prepared records pertaining to treatment of any type after the date of this release as long as this authorization remains valid. This authorization shall be valid for one year from the date of my signature. I understand that when this information is released it may no longer be protected by the HIPAA Federal Privacy Regulation. I also hereby acknowledge that treatment, payment, or eligibility for benefits were not conditioned on my signing this authorization.

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.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client or Personal Representative