

**AUTHORIZATION TO RELEASE and/or OBTAIN CLIENT/PATIENT/STUDENT INFORMATION
LIFELONG ADULT EDUCATION SERVICES INC.**

Name: _____ Date of Birth: _____ Soc. Sec. No. _____

Address: _____

City: _____ State: _____ Zip: _____

I request that my health and/or educational and/or mental health records be released TO / FROM:
(circle one)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

TO / FROM: LIFELONG ADULT EDUCATION SERVICES, INC.
(circle one) 1175 OSAGE STREET, SUITE 201
DENVER, COLORADO 80204
303/573-0839 voice 303/573-0849 fax

ATTENTION: _____

I understand that this information is to be used for psychological evaluation and/or treatment planning.

The information to be released shall include the following:

- | | |
|--------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Educational transcripts | <input type="checkbox"/> Special educational record including IEP's and previous evaluation results |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Evaluation results and diagnoses (psychological/mental health and medical) |
| <input type="checkbox"/> Entire record | <input type="checkbox"/> Other reports: _____ |

I understand that, if my records contain information related to the diagnosis and treatment of drug and/or alcohol abuse, mental health conditions, and/or HIV infections and/or AIDS-related conditions, I am giving permission for the release of information.

I understand that this authorization to release my records will expire in 90 days unless I revoke it, and that I may revoke this authorization at any time. I understand that revocation of this release shall not apply to information released prior to the date of my revocation of this authorization, and that revocation must be on this form and bear my signature and the date signed. I understand that disclosure of this information is voluntary and that refusal to disclose this information will in no way affect my ability to obtain treatment. I understand that any disclosure of this information carries the potential for unauthorized re-disclosure, although neither Lifelong nor its assigns will re-release information from my file without my written consent. Faxed copies of this release form are as valid as the original.

Client Signature Date Witness/Title Date

REVOCAION: Effective immediately, I hereby revoke this authorization to release my confidential records. I understand that any action taken on this authorization before today's date (as indicated below) was legal.

Client Signature Date Witness/Title Date