GREGORY W. GERRITSEN, Ph.D.

FOOTHILLS PSYCHOLOGICAL GROUP
A Professional LLC
2501 Walnut Street, Suite 202
Boulder, CO 80302
Telephone: (303) 473-4433
Fax: (303 442-1125

AUTHORIZATION FOR RELEASE OF INFORMATION

I, *(your name)* _____ *(Date of Birth)* _____,
hereby authorize the exchange of any information pertinent to my treatment between Gregory W. Gerritsen, Ph.D., and

(Name) _____
(Address) _____
_____
_____
(Phone) _____(Fax) _____

Dates of Treatment, if known: _____

Additionally and/or specifically, please send the following information to Dr. Gerritsen (address above):

- ☐ discharge summary
- ☐ psychological testing report
- ☐ psychiatric evaluation
- ☐ treatment summary
- ☐ school records
- ☐ other: _____

I understand that the exchange of information requested above is limited to the person, facility, or agency named and to the dates and purposes stated. I understand that it will be held strictly confidential by the receiver and that it will be used for my benefit. I understand that redisclosure of this information to other persons is prohibited by Federal Law.

This consent shall expire after one year, and I retain the right to rescind this authorization (in writing) any time prior to that.

_____ _____
Date Signature