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