

**CONSENT FOR RELEASE & RETRIEVE OF MENTAL HEALTH INFORMATION**

**Integrative Therapeutic Solutions**

Uptown Denver: 1756 High St. ♦ Denver, CO ♦ 80218

(P) 303-388-8144 ♦ (F) 303-322-3525 ♦ ITSTherapyDenver.com

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

*\*\*Please Note: If consultation is requested and information is to be exchanged between this provider and a third party, the name, address and phone number of the designated third party should be listed in both the **RELEASE** and **RETRIEVE** section below\*\**

I hereby consent to **Integrative Therapeutic Solutions** to **RELEASE** INFORMATION TO THE FOLLOWING PARTIES. This includes written and verbal transfer of history, as well as mental health and treatment information for the purposes of consultation and coordination with relevant professionals.

These Individuals are as follows:

Name	Address	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby consent to **Integrative Therapeutic Solutions** to **RETRIEVE** INFORMATION FROM THE FOLLOWING PARTIES. This includes written and verbal transfer of history, as well as mental health and treatment information for the purposes of consultation and coordination with relevant professionals.

These Individuals are as follows:

Name	Address	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**AUTHORIZATION:** I certify that this authorization to release and/or retrieve has been made voluntarily. I understand the information to be released and/or retrieved may include information related to drug abuse, alcoholism or alcohol abuse. The released and/or retrieved information may also include psychiatric and HIV/AIDS conditions.

I understand that I may revoke this authorization at any time by giving written notice to Integrative Therapeutic Solutions, LLC., except to the extent that Integrative Therapeutic Solutions, LLC. has already taken action on this request. This authorization will expire six months from the date treatment is terminated.

\_\_\_\_\_  
Signature of Client or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

I am revoking consent and authorization to request or release information.	
_____ Signature of Client or Guardian	_____ Date