Patricia Lee, LLC
Licensed Mental Health Counselor
2153 Chuckwagon Road, Suite 202 Colorado Springs, CO 80919
719.268.6882

Consent to Release Information

I, _____, consent that Patricia Lee may

____ Exchange
____ Provide
____ Receive

The following information about my treatment:

____ Treatment summary or progress
____ Diagnosis
____ Attendance
____ Other: _____

With the following persons(s) or entities:

_____ Name/Agency	_____ Name/Agency
_____ Address	_____ Address
_____ City, State Zip	_____ City State Zip
_____ Telephone	_____ Telephone
_____ Fax	_____ Fax

For the purpose of : _____

I understand that once this information is released the recipient might re-disclose it. Privacy laws may no longer protect it. This "consent to release information" form is valid for one year or as allowed by state law. You may revoke this release at any time in writing.

_____ _____ _____
Patient or legally authorized individual signature Date Time

Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

_____