Julieann Myers
Center for Healthy Change

COMPREHENSIVE HUMAN SERVICES, INC., CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION: PROGRAM DISCLOSE TO CFHC

I, _____, authorize _____

(Client Name) (Name/designation of person/program making disclosure)

to disclose to (check one or more boxes):

☐ Julieann Myers, LCSW, MAC, EMDR, CSAT, California License Number 25842 Colorado License Number 991503

☐ Diane L. Moore, LCSW, ACSW. California License Number 28535

☐ Katy Joy Freeman, LMFT Certified, California License Number 38449

☐ Wesley Yu, LMFT Certified California License Number 96881

☐ Jody Helmus, Ph.D. California Psychologist License Number PSY 14567 Massachusetts Number 7916

the following information (Nature of the information, as limited as possible):

_____

The purpose of the disclosure authorized herein is to (Purpose of disclosure, as specific as possible):

_____

Please Provide Contact Information of Person/Program

_____

Phone Number Email

I understand that my records are protected by the Comprehensive Human Services, Inc./Center for Healthy Change confidentiality policies as mandated by C.R.S. 7.714.211. In addition, I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: **1 year from the date indicated below.**
The undersigned certifies that they have read and received a copy of the above policy.

_____

Client/Guardian Date

_____

Therapist Date