Big Spring Counseling, LLC
Jonathan D. Gray, LPC, LAC
10200 E Girard Ave, B-222
Denver, Colorado 80231
(720) 773-1264

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient name: ____________________________________ Date of Birth: ________________

I, the undersigned, do authorize and request:

Big Spring Counseling, LLC
Jonathan Gray, LPC, LAC
10200 E Girard Ave, B-222
Denver, Colorado 80231
(720) 773-1264

to: (check all that apply)

___receive information from ___converse with ___send information to

Name: ____
Address:____
City/State/Zip:____
Phone:___________________________ Fax:_____________________________

This information is regarding my care including information about psychiatric disorders as well as drug and alcohol history. The purpose of this release is for continuity of care.

This authorization will expire after 12 months unless otherwise specified. I may revoke this authorization at any time.

_______________________________________ _________________________

Patient Signature Date

_______________________________________ _________________________

Parent/Guardian/Representative Date