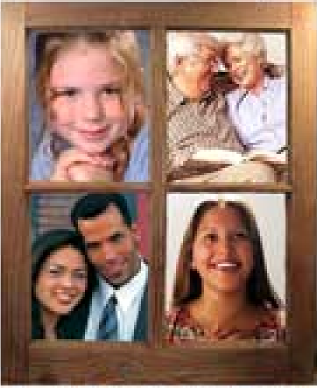

A Window of Hope Counseling Center / Harold W. Anderson LLC

Harold W. Anderson, Ph.D., LMFT, CAC III
324 E. Railroad Ave., Suite 400 Fort Morgan, CO 80701
Phone: 970-380-1160 FAX: 970-205-9462

Your Name

hereby consent to and authorize Harold W. Anderson, Ph.D., LMFT, CAC III and the Window of Hope Counseling Center to obtain from/release to:

Name of Person and/or Facility

Address of Person and/or Facility

information pertaining to my identity, diagnosis, prognosis, and/or treatment plan.

This information is needed for the following purposes (check all that apply):

- To provide ongoing assessment and treatment plan.
- To coordinate treatment with health or mental health care providers.
- To obtain insurance, employment or government benefits.
- To enable judges, attorneys, probation/parole officers, or health personnel to support treatment goals or make legal decisions on my behalf.
- To coordinate treatment with my pastor/religious community.
- To coordinate treatment with my family/concerned persons.
- To coordinate treatment with school counselor(s)
- For educational or supervisory review within that confidential framework,
- Other (please explain in the space provided below

Other

A Window of Hope / Harold W. Anderson LLC Release of Information Form

I understand that by law, I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose specified above. This authorization will have a duration of consent no longer than one year. I understand that I may revoke it at any time except to the extent that action has been taken in reliance on my consent. I understand that I am entitled to a copy of this document in its completed form.

Signature

Date (mm/dd/yyyy)

Signature

Date (mm/dd/yyyy)