Catherine Potyen, MA MFT
P. O. Box 881268
Steamboat Springs, CO 80488
970•879•2111

Authorization for Release of Information

By signing this document, I ____________________________, hereby authorize Catherine Potyen, MA, Licensed Marriage and Family Therapist (License No. 594) to disclose/share information and records obtained in the course of my diagnosis and/or treatment with:

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This disclosure of information and records authorized herein is required for the following purpose:
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Such disclosure shall be limited to the following information:

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This authorization shall remain valid until: ___________________________________

I understand that any cancellation or modification of this authorization must be in writing. I understand also that any revocation of this authorization will not be effective to the extent that I have taken action in reliance on this authorization. I understand that information disclosed pursuant to this release may be subject to re-disclosure and use by the recipient and no longer protected by the HIPAA privacy rule.

_________________________________ ____/____/____

Patient Signature Date