

Mary Monroe, Psy.D.

Grant Street Mansion
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CONSENT TO DISCLOSURE OF CLIENT RECORDS/INFORMATION

I, the undersigned, hereby consent to, direct and authorize Dr. Mary Monroe to () provide, () obtain, or () exchange information concerning my psychological or medical history/treatment. Authorization is thus granted to Dr. Mary Monroe and/or to the following person or agency:

_____ of _____
(Name) (Address and Telephone Number)

The information or records to be released or disclosed include:

- _____ Initial Evaluation/History
- _____ Psychiatric/Psychological Reports
- _____ Medical Information
- _____ Therapy Notes
- _____ Billing Records
- _____ Transfer/Termination Summary
- _____ Tests Taken and Testing Scores
- _____ Other (specify): _____
- _____ Any and all records/Information

I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information released pursuant to this consent and hereby release Dr. Mary Monroe and her staff from any and all liability arising from release and disclosure of the information and records to the above named person.

Client Name (Printed) Client Signature Date

Client Telephone Number Client Address

Witnessed by:

Mary Monroe, Psy.D. (Or Printed Name of Witness) (Signature of Witness)