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### **CONSENT TO RELEASE/REQUEST CONFIDENTIAL INFORMATION FORM**

Client Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security #: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize Dr. Arvind Karwan of Insight Psychological Services, LLC, to release information from records about the above-named Client to the person(s)/organization listed below:

Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_  
\_\_\_\_\_

The purpose for releasing this information is: \_\_\_\_\_  
\_\_\_\_\_.

The information concerns the time between \_\_\_\_/\_\_\_\_/\_\_\_\_ and \_\_\_\_/\_\_\_\_/\_\_\_\_.

In the boxes below, I authorize the information marked by an "X" to be disclosed by Dr. Karwan to the above-named person(s)/organization:

- ☐ Status as being a Client receiving therapy and/or assessment services
- ☐ Dates, types, and attendance of service, and other billing-related information
- ☐ Intake and discharge summaries, including diagnoses and progress in treatment
- ☐ Developmental/social history and family history
- ☐ Psychological evaluation and testing summaries
- ☐ Therapy case/progress notes
- ☐ Information related to drug/alcohol use, including history, current use, and treatment
- ☐ Legal charges and status
- ☐ Educational information
- ☐ Medical information, including history and diagnoses
- ☐ HIV-related information and/or information related to sexually transmitted diseases
- ☐ Other: \_\_\_\_\_

I also do/do not (circle one) authorize Dr. Karwan to request information about the above-named Client from the above-named person(s)/organization for the purpose of service coordination, collaboration, continuity of care, and case management activity. Please write any exceptions to this request for information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have had explained to me and fully understand this two-page consent form to release/request confidential information, including the nature of the records to be released/requested, their contents, and the likely consequences and implications of their release. I understand that signing this consent form is entirely voluntary on my part. I understand that I may revoke this consent at any time, except to the extent that action based on this consent has already been taken. I understand that this consent form may be sent to the person(s)/organization listed above.

This consent expires on \_\_\_\_\_, 20\_\_\_\_ (365 day maximum)

Executed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

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Print Client's Name

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Client's or Responsible Party's Signature

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Date

If signed by Responsible Party, please print name and state relationship to client and authority to consent:

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