Dr. Rohini Gupta
4500 E 9th Ave #660, Denver, CO 80220
720-675-7009

Consent for releasing and retrieving mental health information

Client Name:_______________________________________ Date:_____________________

I hereby consent to Dr. Rohini Gupta to RELEASE INFORMATION to the following parties. This includes written and verbal transfer of history, as well as mental health and treatment information for the purposes of consultation and coordination with relevant professionals.

Individuals/Organization Dr. Rohini Gupta has my permission to release information to:

NAME____

ADDRESS____

PHONE #____

I hereby consent to Dr. Rohini Gupta to RETRIEVE INFORMATION from the following parties. This includes written and verbal transfer of history, as well as mental health and treatment information for the purposes of consultation and coordination with relevant professionals.

Individuals/Organizations Dr. Rohini Gupta has my permission to retrieve information from:

NAME____

ADDRESS____

PHONE #____

I certify that this authorization to release and/or retrieve information has been made voluntarily. I understand that I may revoke this authorization at any time by giving written notice to Dr. Rohini Gupta, except to the extent that Dr. Rohini Gupta has already taken action on this request. This authorization will expire 6 months after the date in which treatment has been terminated.

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Client or Guardian name **Date**

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Witness **Date**

I am revoking consent and authorization for Dr Rohini Gupta to release and/or retrieve information.
Client/Guardian Name/signature________________________________DATE_____________