



Nicoletti-Flater Associates, PLLP

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give my written authorization for Nicoletti-Flater Associates to release the following specified information of the individual named below:

Client Name: _____

Address: _____

Phone Number: _____ DOB: _____

I authorize the information to be disclosed to and discussed with the following individual(s) and/or organization(s):

Name of Individual(s): _____

Name of Organization: _____

The type and amount of information to be disclosed (*specify dates where appropriate*):

- Psychological history / notes _____
- Verification of attendance _____
- Pre-employment screening report _____
- Fitness for duty / violence assessment report _____
- Other _____

I understand that this authorization will expire, without my express revocation, one (1) year from today's date (below). I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand I have a right to a copy of this authorization.

I understand that my authorization for the disclosure of this information is voluntary and I can refuse to sign this authorization. However, if I refuse to sign this Release of Information, the interview/assessment will not be conducted. In addition, my refusal to sign the Release of Information will be reported to the referring agency. Treatment, payment or eligibility for benefits may not be conditioned on obtaining my authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and once the information is disclosed, it may no longer be protected by confidentiality rules.

SIGNATURE OF CLIENT (OR GUARDIAN IF MINOR)

DATE OF SIGNATURE

WITNESS

DATE OF SIGNATURE