Mental Health Release Of Information Form

Patient information	
Name:	Gender:
Date of birth:	Social security number:
Address:	
Email:	Phone number:
Authorization	
Healthcare provider information	
I, _____[patient's name]_____, authorize the following entity to release my information:	
Name / organization:	
Address:	
Phone number:	Email:
Recipient information	
I, _____[patient's name]_____, authorize the release of my information to the following entity:	
Name / organization:	
Address:	
Phone number:	Email:

To release, discuss, or disclose the following:

☐ Full treatment record excluding the following information:

☐ Full treatment record including all health/mental health information

☐ Other (please specify):

For the purposes of:

☐ Treatment/continuing care

☐ Billing or Insurance Claims

☐ Legal Proceedings

☐ Other (please specify):

Expiration

This authorization will expire on _____ or upon the occurrence of the following event:

Revocation of authorization

I, _____[patient's name]_____, understand that I have the right to revoke this authorization at any time by providing a written notice to the entity releasing the information. The revocation will not affect any information that has already been released prior to the receipt of the revocation.

Acknowledgment

I have read and understand the terms of this authorization. By signing below, I authorize the release of my information as specified above.

Name and signature:	Date:
Witness' name and signature:	Date: