Mental Health Release of Information Form

Patient Information					
First Name	Last Name	Date of Birth	Gender		
Address		City	State	Zip Code	
Email		Contact Number			

I. Authorization

I authorize the following named individual or organization,

Authorized Person/Organization

Name	Organization	Contact Number
Address		
City	State	Zip Code

to release, discuss, or disclose the following:

- ☐ Full treatment record including all health/mental health information
- ☐ Full treatment record excluding the following information: _____
- ☐ Other: _____

for the purposes of:

- ☐ Treatment/continuing care
- ☐ Billing or Insurance Claims
- ☐ Legal Proceedings
- ☐ Other: _____

II. Disclosure

I authorize this information to be shared with:

Authorized Person/Organization

Name	Organization	Contact Number
Address		
City	State	Zip Code

Patient Information

First Name	Last Name	Date of Birth	Gender

III. Expiration

This authorization is valid until:

☐ Authorization is revoked through written notice to the authorized person or organization

☐ The following date (mm/dd/yyyy): _____

☐ Other: _____

IV. Statements of Rights

- I understand that I have the right to revoke this authorization, in writing to the authorized person or organization, and at any time, except where uses or disclosures have already been made based upon my original permission.
- I understand that discussions and disclosures already made based upon my original permission cannot be taken back.
- I understand I may not be able to revoke this authorization if the purpose was to obtain insurance.
- I understand that it is possible that information disclosed under the terms of the authorization may be re-disclosed by a recipient and no longer protected by HIPAA privacy standards.
- I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether the individual signs the authorization
- I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature Authorization

Patient Signature

_____ Patient Name (Printed)

_____ Patient Signature

_____ Date

Representative Signature

_____ Representative Name (Printed)

Authority to act on behalf of patient:

☐ Parent of Minor ☐ Guardian ☐ Other: _____

_____ Representative Signature

_____ Date

_____ Minor Individual Signature (If Applicable)

_____ Date