Records Release Authorization

FOR THE RELEASE OF PROTECTED MENTAL HEALTH INFORMATION

By signing this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

Pa	tient Name:		Patient Date of Birth:	
1. 2.	I authorize my provider to to/from the SECOND PARTY a SECOND PARTY		EIVE psychological/psychiat	ric mental health information
	Name:			
	Address:			
	Fax Number:	Phone N	lumber:	_
3.	TYPE OF INFORMATION TO BE DISCLOSED ☐ I authorize disclosure of all health information, including information relating to medical, pharmacy, mer health, substance abuse, and psychotherapy ☐ I authorize only the disclosure of the following information:			
4.	PURPOSE OF DISCLOSURE My health information My health information			of my personal representative; or
5.	Note any exclusions or limitat	ions here:		
sig har au on by pro	ning this authorization. By signive voluntarily given my provide thorization at any time by provide any actions taken prior to the other authorized person/organizers.	ing below, I acknowledger authorization to discloiding a written notice to date my revocation is relation receiving the information receiving the receiving the information receiving the information receiving the receiving receiving the information receiving the receiving receiving the receiving receiving the receiving receiving the receiving receiv	ge that I have read and understand one my records. I understand my provider, however the eceived. I understand that no rmation, and at that point, the	penefits is not dependent on my erstand this document and that I d that I may revoke this revocation will not have an effect my information may be redisclosed the information may no longer be a following the date signed unless
Sig	nature		Date:	
	Authorization is given on this p	patient's behalf due to b	peing a minor or unable to s	ign.
Leg	gal Guardian/Personal Represe	ntative Signature:		Date: