

# Mental Health Release of Information Form

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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

### Receiving Person/Organization

Name	Organization	Contact Number
Address		
City	State	Zip Code

<b>Patient Information</b>			
First Name	Last Name	Date of Birth	Gender
<b>III. Expiration</b>			
<p>This authorization is valid until</p> <p><input type="checkbox"/> Authorization is revoked through written notice to the authorized person or organization</p> <p><input type="checkbox"/> The following date __/__/____</p> <p><input type="checkbox"/> Other: _____</p>			
<b>IV. Statements of Rights</b>			
<ul style="list-style-type: none"> <li>• 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.</li> <li>• I understand that discussions and disclosures already made based upon my original permission cannot be taken back.</li> <li>• I understand I may not be able to revoke this authorization if the purpose was to obtain insurance.</li> <li>• 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.</li> <li>• I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether the individual signs the authorization</li> <li>• I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.</li> </ul>			
<b>Signature Authorization</b>			
<p><b>Patient Signature</b></p> <p>_____</p> <p style="text-align: center;">Patient Name (Printed) <span style="margin-left: 200px;">Patient Signature</span></p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Date</p>			
<p><b>Representative Signature</b></p> <p>_____</p> <p style="text-align: center;">Representative Name (Printed)</p> <p>Authority to act on behalf of patient</p> <p><input type="checkbox"/> Parent of Minor    <input type="checkbox"/> Guardian    <input type="checkbox"/> Other: _____</p> <p>_____</p> <p style="text-align: center;">Representative Signature <span style="margin-left: 200px;">Date</span></p> <p>_____</p> <p style="text-align: center;">Minor Individual Signature (If Applicable) <span style="margin-left: 200px;">Date</span></p>			