

Release of Information form Mental Health

Patient Information

- Full Name: _____
- Date of Birth (MM/DD/YYYY): _____
- Social Security Number: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Phone Number: _____
- Email: _____

Authorization

I, _____, hereby authorize _____ (Name of the Mental Health Institution) to release my mental health records to:

- Name of the Recipient: _____
- Institution/Organization: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Phone Number: _____
- Fax Number: _____
- Email: _____

Information to be Released

- All mental health records
- Therapy notes
- Psychiatric evaluations
- Treatment plans

- **Other (Please specify):** _____

Purpose of the Release

- **Continuing care**
- **Insurance purposes**
- **Legal representation**
- **Personal use**
- **Other (Please specify):** _____

Expiration of Authorization

This authorization will expire on (Date): _____.

Patient Rights

- I understand that I have the right to revoke this authorization at any time by notifying the releasing institution in writing, except to the extent that action has already been taken based on this authorization.
- I understand that the information released is subject to re-disclosure by the recipient and might not be protected by federal privacy regulations.
- I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Signature

- **Patient's Signature:** _____
- **Date:** _____
- **Legal Representative Signature:** _____
- **Relation to Patient:** _____
- **Date:** _____