AUTHORIZATION TO RELEASE MENTAL HEALTH INFORMATION

I, _____ understand that the information contained in my
(name of patient)

record is confidential. However, I give my consent for _____ at
(name of therapist)

_____ to release my
(therapist address)

Mental Health treatment records from _____ to _____ , or information concerning such records to:
(date) (date)

_____
(specific therapist or organization)

_____
(address)

for the specific purpose of _____
(specific nature and extent of information to be released)

I authorize the release of the following information obtained in the course of diagnosis and treatment: (initial authorized)

_____ Assessment results and recommendations

_____ Testing / Screening results

_____ Progress Note / Case Notes

_____ Consultations / Evaluations

_____ Education progress / Grades

_____ Other: (specify) _____

I understand that I may revoke this consent at any time by mailing a written revocation to the MEA Privacy Officer, except to the extent that action has already been taken on this authorization. I further understand that this consent Will expire upon _____ and cannot be renewed without my written consent. I understand that any
(not to exceed one year)

information disclosed may be re-disclosed by the recipient, and that all such information would no longer be protected by federal privacy regulations. I understand that I may refuse to sign this authorization and my refusal will Not affect my ability to obtain treatment, payment, or eligibility for benefits.

_____ _____
Signature of Patient (adult or minor) Date

_____
Parent / Guardian Signature (specify relationship)

PATIENT IDENTIFYING DATA

_____
(last name) (first name) (middle) (date of birth)

_____ _____
(social security number) Guardian Name